SOCIAL SECURITY ADMINISTRATION DISABILITY DETERMINATION AND APPEALS PROCESS

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

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CONTENTS

Page

Press releases of Wednesday, April 17, 1991, and Tuesday, April 30, 1991, announcing the hearing 2

WITNESSES

U.S. Department of Health and Human Services, Social Security Administration, Hon. Louis D. Enoff, Principal Deputy Commissioner of Social Security 15

U.S. General Accounting Office, Joseph F. Delfico, Director, Income Security Issues, Human Resources Division and Barry Tice, Assistant Director, Disability Programs 39

Administrative Conference of the United States, Marshall J. Breger 53
Alternative Coping Resources, Inc., Charles E. Romero 185
American Bar Association, John H. Pickering 71
American Federation of Government Employees, AFL-CIO, John Gage 127
Archer, Hon. Bill, a Representative in Congress from the State of Texas 5
Breger, Marshall J., Administrative Conference of the United States 53
Christopher, Tom, National Association of Disability Examiners 132
Flemming, Hon. Arthur S., Save Our Security Coalition 49
Gage, John, American Federation of Government Employees, AFL-CIO 127
Goldstein, Stewart, National Treasury Employees Union 139
Griffin, Bertha, Baltimore, Md 8
Health Insurance Association of America, John S. Roberts 180
Katz, Nancy, Legal Assistance Foundation of Chicago 167
Kress, Stan, National Council of Disability Determinations Directors 117
Legal Aid Bureau, Inc., Ethel Zelenske 143
Legal Assistance Foundation of Chicago, Nancy Katz 167
Legal Services of New York City, Barbara Samuels 155
National Association of Disability Examiners, Tom Christopher and Carroll D. Moore 132
National Committee To Preserve Social Security and Medicare, Max Richtman on behalf of Martha McSteen 175
National Council of Disability Determinations Directors, Stan Kress 117
National Organization of Social Security Claimants' Representatives, Meyer Silver 163
National Senior Citizens Law Center, Eileen P. Sweeney 104
National Treasury Employees Union, Stewart Goldstein 139
Pickering, John H., American Bar Association 71
Rangel, Georgia, Alexandria, Va 9
Richtman, Max, on behalf of Martha McSteen, National Committee To Preserve Social Security and Medicare 175
Roberts, John S., Health Insurance Association of America 180
Romero, Charles E., Alternative Coping Resources, Inc 185
Samuels, Barbara, Legal Services of New York City 155
Save Our Security Coalition, Hon. Arthur S. Flemming 49
Silver, Meyer, National Organization of Social Security Claimants' Representatives 163
Sweeney, Eileen P., National Senior Citizens Law Center 104
Zelenske, Ethel, Legal Aid Bureau, Inc 143

SUBMISSIONS FOR THE RECORD

	Page
Allsup Inc., Belleville, Ill., James F. Allsup, letter	189
American Association of Retired Persons, statement and attachments	192
Bryant, David R., Chicago, Ill., letter	198
Consortium for Citizens with Disabilities Social Security Task Force: American Foundation for the Blind; Association for Retarded Citizens of the United States; American Association of University Affiliated Programs; Epilepsy Foundation of America; Mental Health Law Project; National Association of Private Residential Resources; National Association of Protection and Advocacy Systems; National Association of State Mental Retardation Program Directors; National Head Injury Foundation; National Mental Health Association; and Paralyzed Veterans of America, Martha E. Ford and Joseph Manes, joint statement	201
Council of State Administrators of Vocational Rehabilitation, James B. Griffith and Joil A. Southwell, joint letter	203
Evers, Gregory W., Charleston, W. Va., letter	206
Florida Rural Legal Services, Inc., Douglas L. Wilson, Immokalee, Fla., statement	207
Franklin Pierce Law Center, Concord, N.H., Bruce E. Friedman, letter	210
Harlan, Timothy C., Columbia, Mo., letter	212
Hughes, Hon. William J., Chairman, Subcommittee on Retirement Income and Employment, Select Committee on Aging, and a Representative in Congress from the State of New Jersey, statement	214
Massachusetts Rehabilitation Commission, Elmer C. Bartels, statement	216
Mellinger, Dave, Sandy, Utah, letter	221
Patterson, Rudolph H., Macon, Ga., statement	222
Rains, Robert E., Disability Law Clinic, Dickinson School of Law, Carlisle, Pa., letter and attachment	231
Santa Clara County (Calif.) Social Services Agency, Richard R. O'Neil, letter and attachment	233
Thomason, George H., Spartanburg, S.C., statement	239

SOCIAL SECURITY ADMINISTRATION DISABILITY DETERMINATION AND APPEALS PROCESS

THURSDAY, MAY 2, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON SOCIAL SECURITY,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:30 a.m., in room B-318, Rayburn House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
WEDNESDAY, APRIL 17, 1991

PRESS RELEASE #3
SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

ANDY JACOBS, JR., (D., IND.), CHAIRMAN,
SUBCOMMITTEE ON SOCIAL SECURITY, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE
SOCIAL SECURITY ADMINISTRATION (SSA)
DISABILITY DETERMINATION AND APPEALS PROCESS

Andy Jacobs, Jr. (D., Ind.), Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on the Social Security Administration (SSA) disability determination and appeals process. The hearing is part of the Committee on Ways and Means' major oversight initiative for the 102nd Congress, which examines the efficiency and effectiveness of programs within the Committee's jurisdiction. This hearing will focus on means of improving the accuracy of SSA decisions on disability claims and streamlining agency appeal procedures. It will be held on Thursday, May 2, 1991, beginning at 10:00 a.m., in room B-318 of Rayburn House Office Building.

BACKGROUND

When an individual applies for social security disability benefits, his application is evaluated by a State Disability Determination Service (DDS). Funded by SSA, these agencies collect medical evidence of the claimant's condition and assess his potential to work. When a DDS denies an application, the claimant may apply for so-called reconsideration -- a review of his file by another DDS examiner. If this review confirms SSA's original decision, the claimant may then request a hearing before an administrative law judge (ALJ).

In recent years, these procedures have been criticized on two counts, the accuracy of decisions and extended delays. As evidence of inaccuracy, critics cite ALJs' high rate of reversal of SSA decisions. While only about 15 percent of initial decisions appealed are reversed at the reconsideration level, the ALJ reversal rate for decisions appealed from reconsideration has consistently exceeded 50 percent over the past decade; and in 1990, it reached nearly two-thirds, or 63 percent. The second problem, long delays, is reflected in SSA's statistics on claims processing. These statistics show that it currently takes more than three months for SSA to reach an initial decision on a typical disability case; that another two months is required for reconsideration; and that disabled claimants must wait on average a full seven months for an ALJ decision.

To address these problems, Chairman Jacobs recently introduced H.R. 1799, the Disability Appeals Process Reform Act of 1991. H.R. 1799 would: (1) require SSA to provide initial face-to-face interviews for all applicants for disability benefits; (2) eliminate reconsideration; and (3) direct SSA to develop more comprehensive initial evidence of the claimant's condition. This information would include: relevant physician, hospital and clinic records; detailed statements from claimants themselves; reports by non-medical professionals such as physical therapists; and statements by claimants' families and friends.

FOCUS OF THE HEARING

The hearing will seek to identify factors that account for inaccuracy and delays in SSA decision making and to identify measures that would address both these problems. Witnesses are invited to give specific attention to the following issues:

* Why are SSA disability determinations so frequently reversed on appeal? Why is the reversal rate rising?

* Can SSA decision making be improved by expanding the information on which decisions are based? If so, what additional information should be gathered? Specifically, would a face-to-face interview before an initial decision improve the quality of decisions?

* What can be done to improve the timeliness of SSA decisions? Can the process be shortened or streamlined while maintaining the rights of claimants? If so, how?

(MORE)

* Some critics of the current disability determination process have pointed to the DDSs' insularity as a cause of decision making errors. Is this a widespread problem? If so, would the establishment of DDS advisory groups consisting of medical and legal experts, government representatives, and advocates for the disabled improve the accuracy of decisions?

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Requests to be heard at the hearing must be made by telephone to Harriett Lawler or Diane Kirkland [(202) 225-1721] by noon, Monday, April 29, 1991. In order to facilitate scheduling, requests should indicate the specific issues that the witness wishes to address. The telephone request should be followed by a formal written request addressed to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee staff at [(202) 225-9263].

In view of the limited time available to hear witnesses, the Subcommittee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

Witnesses scheduled to present oral testimony are required to summarize briefly their written statements in no more than five minutes. THE FIVE-MINUTE RULE WILL BE STRICTLY ENFORCED. Subcommittee Chairman Jacobs advises witnesses that they will be allowed no more than two "finally's" and one "in conclusion." The Congressional Budget Office and similar U.S. Government agencies may be granted an exception. The full written statement of each witness will be included in the printed record.

In order to assure the most productive use of the limited amount of time available to question witnesses, those scheduled to appear before the Subcommittee are required to submit 100 copies of their statements to the Subcommittee on Social Security office, room B-316 Rayburn House Office Building, at least 24 hours in advance of their scheduled appearances. Failure to do so may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement by the close of business, Thursday, May 16, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing a written statement wish to have their statements distributed to the press and interested public at the hearing, they may deliver 100 additional copies for this purpose to the Subcommittee, room B-316 Rayburn House Office Building, on the day of the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

***

* * NOTICE -- CHANGE IN TIME * *

FOR IMMEDIATE RELEASE
TUESDAY, APRIL 30, 1991

PRESS RELEASE #3-REVISED
SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

ANDY JACOBS, JR. (D., IND.), CHAIRMAN,
SUBCOMMITTEE ON SOCIAL SECURITY, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A CHANGE IN TIME FOR
THE SUBCOMMITTEE HEARING ON THE SOCIAL SECURITY ADMINISTRATION (SSA)
DISABILITY DETERMINATION AND APPEALS PROCESS

Andy Jacobs, Jr. (D., Ind.), Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee hearing on the Social Security Administration (SSA) disability determination and appeals process scheduled for Thursday, May 2, 1991, will begin at 10:30 a.m., instead of 10:00 a.m. as announced earlier.

All other details for the hearing remain the same (see press release #3, dated April 17, 1991).

* *
* * *

Chairman JACOBS. The subcommittee will come to order.

Our first witness is Mr. Bill Archer, a member of the House Ways and Means Committee. Mr. Bill Archer, of Texas, is a good singer and a very, very bright Member of Congress.

Please proceed.

STATEMENT OF HON. BILL ARCHER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. ARCHER. Mr. Chairman, I first thank you for holding these hearings. I think they are very important and I am delighted to have the opportunity to lead off in testifying to your committee this morning.

This hearing on disability determination and appeals process represents, I think, a welcome opportunity to discuss with you my bill, the Procedural Improvement Act of 1991, H.R. 2159. It is a bill I first introduced in 1986, to respond to the thorny issues addressed in the Disability Amendments of 1984.

Although many of the problems we addressed in those amendments have lessened, some, as your press release indicates, remain. My bill would address two, the clear need to streamline the process, and, second, the lack of uniformity, the lack of uniformity between the States, between the States and the ALJs and, finally, between SSA and the courts.

The bill has three main provisions. It would liberalize the criteria under which the Secretary could federalize the State agencies, which make the initial and reconsideration decisions; second, it would eliminate the Appeals Council and the review it performs; and, third, create a Social Security Court, a proposal first advanced by our colleague Jake Pickle.

In my opinion, enhancing the Secretary's authority to federalize the Disability Determination Service would enhance Social Security's authority to promote greater uniformity in the initial claims process. I would note, Mr. Chairman, that this change is supported by the report of the 1986 Disability Advisory Council, which recommended that the takeover process be streamlined, and came close to recommending that State agencies be federalized. In the end, the benefit of decentralized administration won out. My bill would facilitate, but not mandate, federalization.

Eliminating the Appeals Council, the "black hole," as I believe some critics have characterized it, would facilitate the flow of cases into the court.

Finally, my bill would create a Social Security Court, modeled after the Tax Court. I want to stress that my intent is not so much to stifle legal interpretation of statutory and regulatory requirements as to quantify those interpretations so that the issues and costs can be more speedily resolved by the administration and Congress.

Currently, the SSA acquiesces to adverse circuit court cases, until or if such decisions are overturned on appeal. Relatively few of the published acquiescences in the past 6 years have related to the evidence or even the process used to evaluate disability cases.

The overwhelming majority have involved the OASDI and SSI programs. These have centered on the evidentiary requirements,

for example, death, marriage and adoption, and questions of income. These are simply not regional issues and should not differ from one region to another. I am convinced that a Social Security Court would bring a refreshing level of expertise to these cases and reestablish national uniformity in a program which is developing untenable administrable fusions.

Mr. Chairman, my bill would attempt to promote greater uniformity at the top and the bottom of the process, and expedite the relatively small number of cases appealed to the courts.

Your bill, H.R. 1799, has a much more substantive impact on workload. It would, I believe, reduce the workload of the States by over 20 percent, but almost triple the workload of the ALJs. Given the 7-month backlog at the ALJ level and the comparative cost of a hearing, I wonder if that really will improve things. I would be glad to discuss this with you either today or at some future time. But, I am sympathetic to what you are attempting to do.

I seem to remember we discussed this when the Disability Reform Amendments were developed. At that time, we asked SSA to pilot a series of demonstration projects, testing face-to-face interviews at the reconsideration stage. I do not recall seeing a report. Perhaps SSA can provide the results today. It would seem to offer a more timely and cost-effective determination, if enough claims are allowed at that stage to justify its retention.

Mr. Chairman, thank you for this opportunity to testify. I hope, as you consider legislation, you will keep my proposals in mind, and I know that you will, from previous experience. Perhaps some of our witnesses today that you have scheduled, would care to comment on this proposal.

Chairman JACOBS. An excellent statement.

Cochairman Mr. Bunning.

Mr. BUNNING. First of all, I appreciate Mr. Archer, our ranking member, being here. I would like to also include in the record my opening statement.

Chairman JACOBS. Or you can make it.

Mr. BUNNING. No, it is too long.

Thank you for your information. We are anxiously looking forward to the rest of the testimony, and some of the other people might like to comment on what you have said.

Thank you.

[The opening statement of Mr. Bunning follows:]

OPENING STATEMENT OF HON. JIM BUNNING, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. Chairman, thank you for scheduling today's hearing. I understand that the subject, the disability determination and appeals process, has been a long-standing concern to you and this subcommittee. Problems with delays, lack of uniformity and charges that the current system does not help the people it's intended to serve show that reforms clearly are necessary.

The lack of uniformity is especially distressing to me, especially when I look at some composite figures of the disabled in Kentucky, Indiana, and Texas. These States have significantly lower allowance rates than, for instance, those living in Washington State.

If I combine the percent of those allowed at the initial claim level with those who are deemed disabled at reconsideration, Texas approves 42 percent, Kentucky approves about 43 percent, and Indiana 46 percent. Washington, on the other hand, approved almost 72 percent in fiscal year 1990. When you compare all of this to the

national average—56 percent—the numbers illustrate the woeful lack of uniformity. However, I must note that these numbers aren't statistically valid because 17 percent of those who are initially denied do not appeal.

Mr. Chairman, your bill, H.R. 1799, addresses this lack of uniformity by expanding the medical evidence used in the disability determination process. Your bill would also expedite the appeals process by eliminating the reconsideration step. I applaud your efforts to ensure that complete medical evidence is used in this process. I do, however, have some reservations about the elimination of the reconsideration step.

It might be more cost-effective if we mandate the first face-to-face interview to be done in conjunction with the initial claim. Unless a case is clearly terminal, reinstating an in-person interview and a well-detailed background report completed by a claims representative seems to be that "first step" in improving quality and processing times.

And, hopefully, GAO will comment on the disability teleclaim. I question whether this is as effective as the face-to-face interview it has replaced.

Also, elimination of the reconsideration may increase the costs associated with the appeals process. The average reconsideration costs $260 with a processing time of about 2 months, while the administrative law judge review takes over 7 months at a cost of $810. I wonder if the transition would end up saving time or money.

However, there might be another alternative—in 1984, Congress mandated an SSA pilot project. It allowed State agencies to conduct a face-to-face interview during reconsideration. Of course, if the State agency or DDS is not within a reasonable distance from a particular region, "satellite offices" might need to be set up for the convenience for those we're trying to serve.

From what I understand, the costs were much lower using this approach. In fact, SSA was supposed to release a report on the costs and success of the pilot, in 1986. However, we've never received a report on the pilot. Perhaps SSA will enlighten us.

I want to thank those who are here to participate today and I look forward to your testimony. Hopefully we'll get some sound suggestions on how the disability and appeals process can be improved. And Mr. Chairman, thank you for holding this much-needed hearing.

Chairman JACOBS. Thank you.

Mr. Cardin.

Mr. CARDIN. Mr. Chairman, I want to first thank you for holding these hearings. This is an extremely important subject, dealing with why it is taking so long for some of these hearings to take place and ways in which the process might be streamlined..

I want to thank Mr. Archer for his concern and interest in this area, and his suggestion certainly gives us a point to start debate on how to improve the way disability claims are being handled.

I would just like to note, Mr. Chairman, some of the people that you have invited. I notice that you have three that live in Baltimore. Bertha Griffin, who lives in my area, is on the first panel, and I would like to welcome her. You also have an attorney from the Legal Aid Bureau, Ethel Zelenske, and, last, John Gage, who represents many of the employees in Social Security. I am glad to see that you are calling on experts from Baltimore.

Chairman JACOBS. Is that the end of the commercial? [Laughter.]

Bill, thank you very much for your contribution.

Mr. ARCHER. Thank you, Mr. Chairman.

Chairman JACOBS. We certainly shall, as you assume, take seriously your proposals. I guess we are all after the same thing. I think that we are going to receive the GAO report today that indicates that elimination of reconsideration and the requirement for a face-to-face hearing would increase the costs of the Social Security system, which, at first blush, would seem undesirable.

On the other hand, if you are shortchanging someone and you decide to give the person the correct change, the cost to your business has been increased. However, the cost to your soul has been

decreased. So, if the cause of the increased expense is to pay those who are, in essence, being denied their legal rights now, then I think that possibly the Federal Government can afford justice, so we will take that into account, as well.

Mr. ARCHER. Well, I look forward to working with you and the members of your committee on this task.

Thank you very much.

Chairman JACOBS. Thank you, Bill.

The next witness is from Baltimore, Md., Ms. Griffin, and Ms Rangel from Alexandria, Va. We are very pleased to call you forward.

We know you ladies are not professional witnesses, and we want to tell you right from the start, people are people, so there is no reason to be nervous about this at all. We will learn more from you than we will learn from most people today, and we are very grateful for your willingness to come in.

STATEMENT OF BERTHA GRIFFIN, BALTIMORE, MD.

Ms. GRIFFIN. Good morning. My name is Ms. Bertha Griffin. I am the mother of the late Nicholas Griffin, who died April 6, 1991.

My son applied for SSI in September of 1989. He was sick then and unable to work. In fact, he had not been able to work for many years preceding that. He was getting social service from the State when he first applied. The Social Security Administration wanted him to be examined by his doctors, which he did. Months later, they wanted him to get his records from his doctors, which he did.

I think the thing that stands out in my mind is the fact that a State doctor had already wrote in a letter that Nicholas was unable to work anywhere. He has had terrible bouts with deep depression and was suicidal, so much that he had to visit the psychiatrist as often as twice a week.

He was also being treated for very high blood pressure, diabetes, and pancreatitis. He was in so much pain, that many a night he would pace back and forth in his room. Finally, the doctors gave him a TNS unit to wear, but it did not help much. Of course, he was in and out of the hospital an awful lot. He was very irritable at times and very weak. Some days, he would stay in bed just about the whole day and ate very little. He lost so much weight, 21 pounds in 2 weeks.

He got a letter from the Social Security Administration a few months later, asking for records from the hospital, and I am sure they could see he was getting worse. Still, the Social Security Administration asked for different forms from his doctors. Then there would be another long wait.

Another 3 or 4 months would pass and he would get a letter that another hearing was needed. In the meantime, my son's illness got worse. Well, in February of this year, my son got another letter for yet another hearing, but the judge wrote that the medical reports in his file were enough, and he found that he was qualified, with no need for one.

So, my son Nicholas finally became eligible in March, and then he died in April. So, please, do not have so many hearings based so far apart.

Thank you.
Chairman JACOBS. Thank you, Ms. Griffin.
Ms. Griffin, I believe this is your daughter?
Ms. GRIFFIN. My daughter.
Chairman JACOBS. Ms. Rangel.

STATEMENT OF GEORGIA RANGEL, ALEXANDRIA, VA.

Ms. RANGEL. I have a progressive degenerative neurological problem similar to Parkinson's. My last two jobs, I was not able to learn. This is because my condition affects my cognitive abilities. In addition, I walk with a walker. It is very painful moving around. I have seizures, muscular seizures which are painful and certainly distracting.

Finally, in November 1989, I stopped working. In January 1990, I put in my first application for Social Security disability. I had talked to them on the phone in December. I was denied in April of 1990, and I was denied again in September, and then, finally, I got my hearing in April, just last week.

One thing about that is they really did not indicate what they needed from me, at least so that I could understand. In fact, I am lucky that Mr. Dallas from Legal Aid put everything together to show what my problem is and how it affects me.

Now, what all of this caused in my life is what I wanted to tell you. My daughter, who has learning disabilities lost her job in November. She is now being trained by the Virginia Department of Rehabilitative Services, and she has a daughter. Our rent is $700, and our income is $730. That is until the city had to cut general relief, which I am getting. I have to pay the general relief money back as soon as I get Social Security.

At the same time, my work health insurance was dropped. I had been spacing my doctors visits more than he wanted, because I could not pay the extra. At this point, I could no longer get my medicine, which costs me about $6 a day. Previously, my insurance paid for it. I went and applied for Medicaid. Medicaid said you cannot have Medicaid until you have your Social Security disability.

A couple of weeks later, I had two kidney stone attacks. We have applied for State and local funds, but I have 2,000 dollars' worth of bills that will not be covered, and we have had to borrow money for the rent.

I went to the local clinic and I asked them if I could get my care there at the health clinic and get my medicine there. They said no, they do not have a neurologist. So not having Social Security disability just makes it impossible to get medicine and medical care.

I have coming from the State of Virginia a pension, also, which I cannot have yet, because Virginia depends on the Social Security decision. That way, I guess they don't have to have another decision system.

So, this has affected us financially, and in health, in a lot of ways. For 4 days after I got out of the hospital with kidney stones I could not get pain medicine. I tried to get my medicine for pain, but social services could not pay for it. Finally, my clergyman, I told him and he paid for it.

That is a long time to wait for pain medication.

I think one thing Social Security could do is make sure there is someone to help those who do not understand or cannot apply themselves, and maybe have a kit to guide a person, because I would have given up, without Legal Aid.

Thank you.

[The prepared statement follows:]

Testimony of

Georgia Rangel

May 2, 1991

My name is Georgia Rangel. I am 49 years old. In November 1989, I went on leave without pay from my job. January of 1990, I applied for Social Security Disability. Before that I had worked for the Commonwealth of Virginia for 7 years 11 months. My last position was as a program support technician doing accounting and contracts work for the Virginia Department of transportation.

I was denied within two months. I requested reconsideration and was notified on April 5th I had been denied. This second denial was apparently based on a report from my doctor which Social Security had requested. This report was on my range of motion which in my condition is relatively normal. Through the Legal Aid organization, I applied for a hearing. I had my hearing on April 24, 1991. But the long wait has been hard on me and on my daughter and her infant with whom I now live.

When my savings ran out, I applied for General Relief and Food Stamps from the City of Alexandria Social Services. (If I get Social Security Disability, the General Relief money will have to paid from my first check.) We were getting along on my 23 year old daughter's salary, though it was tight. Then in November 1990, she was laid off.

My daughter, who has learning disabilities, turned to Virginia Department of Rehabilitative Services for training. Our combined income dropped to $730. Rent on my daughter's apartment is $700. Then the City of Alexandria notified me in February that General Relief was cut from $220 per month to $145. I had been spacing my doctor's visits more widely than the doctor wanted because I didn't have enough money to pay what my insurance did not. Then in February my job dropped me from

the group insurance. I take an anti-Parkinson's drug that cost about $6 a day. My health insurance had been paying for it. Now I had no way to pay for it. I went to apply for Medicaid but was told that I cannot have Medicaid until I have Social Security Disability. I went to the Health Department clinic and was told I could not get my care nor medicine there because they have no neurologist.

March 21, 1991, I had an attack of kidney stones (which I had never before had). I was in the emergency room that day, had another attack the next day and was hospitalized. My daughter applied for my hospitalization to be paid for by State and Local Hospitalization funds. Even if I get that, I have close to $2,000 in bills these funds don't cover including ambulance, radiologists, and others. For 4 days after I got out of the hospital, I tried to find a way to get my pain medication. Social Services couldn't help me so finally, I appealed to my rabbi who got it for me. Four days is a long time when a person is in pain.

I am eligible for disability income from my Commonwealth of Virginia job. But they follow the Social Security Disability decision. If I get Social Security Disability I will also get disability from my job, but not until the Social Security Disability case is decided.

Just living expenses have been difficult to come by these last few months and we have had to borrow $450 to pay rent. My credit rating has been excellent, but now I worry that if we cannot pay these extra bills from my hospitalization, as well as normal expenses, my credit rating will be ruined.

In February, I appealed to Congressman Moran's office to help me get a hearing. Without the intervention of his office I doubt I would have got it last week.

When we went to the hearing with the Administrative Law Judge, the Legal Aid person took a stack of medical records at least one inch thick. If you look at the form on which one

applies for Social Security Disability, you can see that there is a space about 3 inches long to give them information about the disability that has not been covered by their questions. It doesn't say what kind or number of records should be sent. My disability affects my cognitive processes as well as my muscles. But I am expected to understand and fill out the papers and to know when I should contact Social Security. My first contact was by phone and the rest has been letters Social Security sent me. I am thankful I was referred to Rueben Dallas of Legal Aid or I would not have gotten this far in the process.

Chairman JACOBS. Thank you.

Mr. Bunning.

Mr. BUNNING. I do not have any questions.

Chairman JACOBS. Mr. Cardin.

Mr. CARDIN. Well, I want to thank both Ms. Griffin and Ms. Rangel for being here. We hear the statistics about how many people are having difficulty in having claims processed, and we look at those figures and we try to act, but your presence here today puts a face on the problem. I just want both of you to know how much I personally appreciate you making the effort to appear before our committee. It is extremely useful for us to hear first-hand the hardships that are caused, because of delays in reaching decisions.

Ms. Rangel, if I understand your testimony correctly, you first applied for benefits in January of 1990, and it took until April 1991 before you had a hearing?

Ms. RANGEL. Yes.

Mr. CARDIN. You had a lawyer.

Ms. Griffin, did you also have an attorney help you?

Ms. GRIFFIN. My son got a Legal Aid lawyer, finally.

Mr. CARDIN. So, both of you had the assistance of an attorney to help you.

Ms. GRIFFIN. Yes.

Mr. CARDIN. I take it that if you did not have the assistance of that attorney, you probably would not have been successful.

Ms. RANGEL. I would have dropped out. Somebody told me, my daughter's vocational rehabilitation person told me to go to this man at Legal Aid, otherwise, probably after the first one, I would have just not been able to do it.

Mr. CARDIN. Is that true also, Ms. Griffin, with your son's case?

Ms. GRIFFIN. He was in the psychiatric ward, and the doctor suggested that he try to get on SSI, and I think guided him to a lawyer, the social worker first.

Mr. CARDIN. I just really wanted to underscore that, because I think a point that you raised is the fact that there really is not adequate information available for you to handle your own case. Is that what you were indicating?

Ms. RANGEL. Yes.

Ms. GRIFFIN. That is right.

Mr. CARDIN. Thank you very much.

Chairman JACOBS. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I simply want to thank both witnesses for coming. Mr. Cardin said it as I would, that it is important for people like you to come and tell us the stories. Sometimes we read letters, and it is always nice to see somebody in person who has gone through this. It makes it a lot easier for us to explain why we need to make some changes in the system.

I worked as a psychiatric examiner on a lot of SSI cases, so I know the issue from the other side, and I understand what people go through, and it is clear that the system is set up to keep people from getting benefits. That is not the way it was originally set up, but that is the way it is now being implemented, and I think that is what we are trying to change here.

So, thank you for coming and helping us with that.

Ms. GRIFFIN. I know it will not help my son, but I am hoping we being here today will help someone else.

Mr. MCDERMOTT. That is a very noble thought.

Chairman JACOBS. Chairman Pickle.

Mr. PICKLE. Mr. Chairman, I was not privileged to hear the testimony, but I am sympathetic.

Chairman JACOBS. He probably is. [Laughter.]

Thank you very much for your contribution. We appreciate it very much.

Ms. GRIFFIN. Thank you. May I say something, please, to Mr. Cardin?

Chairman JACOBS. Yes.

Ms. GRIFFIN. Mr. Cardin, I am also of your district, Local 239 UAW, so I know you are a good man up there.

Mr. CARDIN. Thank you. I am glad I am being watched. That is a much better commercial than the first one. [Laughter.]

Chairman JACOBS. Thank you very much.

Ms. GRIFFIN. Thank you.

Ms. RANGEL. Thank you.

Chairman JACOBS. Our next witness, representing Commissioner King, Louis Enoff, from the Social Security Administration, a real stranger in these parts.

STATEMENT OF LOUIS D. ENOFF, PRINCIPAL DEPUTY COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. ENOFF. Thank you, Mr. Chairman.

I, too, commend you for holding these hearings and I, too, would thank the witnesses who have come this morning to tell us some of the problems that we all face and that we are trying to work together to resolve. I do appreciate the interest of the members of this committee.

I have extensive written testimony, which I will submit for the record, and I will use my allotted 5 minutes to answer the questions you posed in your letter of invitation.

There is one very salient fact, Mr. Chairman, that sets the backdrop against which I think we have to consider all of the other issues within the disability area right now, and that is the dramatic increase in the number of disability claims being filed, almost 10 percent over our budgeted number. In just 1 year, from fiscal year 1989 to fiscal 1990, the number of initial disability claims pending in the State Disability Determination Services or the DDSs, as we refer to them, has increased by over 30 percent.

If we combine those increases with the growing complexity of the disability program and the intensified emphasis we are placing on the quality of decisions, and add to it a DDS funding level that did not increase in real terms from fiscal 1988 until fiscal 1991 when we achieved a desperately needed increase, we have a disability determination program that is stretching its human and fiscal resources very tight in order to achieve acceptable levels, both of accuracy and timeliness.

Let me discuss those two qualities separately, beginning with the accuracy element. As you said in the statement you sent out, Mr. Chairman, critics have cited the frequency with which administrative law judges (ALJs) allow benefits to previously denied claimants as a rationale for criticizing the quality of the disability determination process.

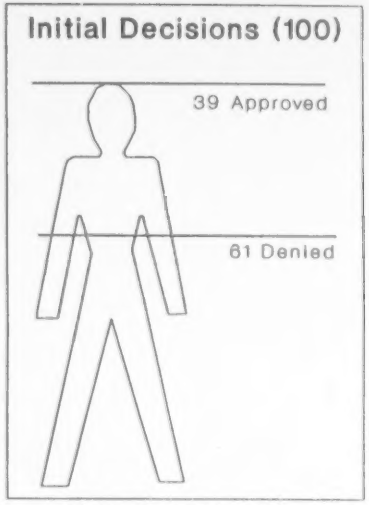
There is a problem with this particular line of reasoning, and, if I might, Mr. Chairman, I would like to show the committee a chart, if I could have someone bring that chart forward.

[The chart follows:]

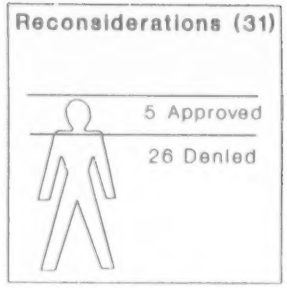
LEVELS OF DISABILITY ALLOWANCE DETERMINATIONS

FY 1990

(per 100 cases)



31 File Reconsideration



17 File Hearing

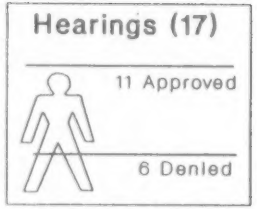


CHART 1.1

The fact is that, in any given time period, State DDS accuracy rates range from about 90 to 98 percent. In the quarter that ended last March, the national overall DDS accuracy rate was 94.4 percent. Now, it is a reasonable question, then, to ask why do the administrative law judges allow——

Chairman JACOBS. Excuse me. If that fellow would turn that easel a little bit, I believe the audience and the subcommittee could see it, just point it straight south.

Mr. ENOFF. A copy of the chart is being distributed to the members.

Well, the question arises, if the accuracy is good, why do the ALJs allow so many previously denied claims? This chart, I think, graphically displays that ALJs do allow 60 percent of the claims they see, but that represents only 20 percent of the persons who are allowed benefits. Fully 80 percent of the persons receiving disability benefits are allowed by the DDSs, and that is a point that I think we have to keep in mind. We do need to improve the ALJ process and the timeliness, but the vast majority of persons who are allowed benefits are allowed at the DDS level, 80 percent, and that is the point I want to make with that chart.

Now, you notice that I have not used the term "reversal," when I talk about the ALJ actions. I have not used that term, because I do not think it is the proper term to use. We all know that the judges are often making decisions on cases that are very different from those that are considered by the initial disability examiner.

The Social Security Act permits claimants to submit additional and different evidence at the hearing level than was initially presented at the DDS. Also, at the hearing level, more than 80 percent of those who appeal their initial ruling are represented by counsel, and these are usually attorneys, who help the claimant—as we heard in earlier testimony—obtain new evidence and explain the impairment in a more precise way to the administrative law judge.

Furthermore, in that time lapse, which we all want to shorten, between the initial decision and the ALJ hearing, the claimant's condition may worsen or an anticipated improvement in a condition may not materialize. The definition of disability in the statute is that the impairment must be expected to last for at least 12 months.

In short, the ALJ is often making a new decision on a substantially different case from the one that was reviewed accurately earlier in the process. Despite the fact that accuracy rates are high, however, we recognize that the presence of any error rate means that some whose claims have been denied may not be receiving benefits to which they are entitled under the law.

In addition, the high overall accuracy rate does not reflect the fact that accuracy rates in a handful of States are less than acceptable.

To address these matters, we are taking steps to further strengthen the initial stages of the process. We are undertaking a joint DDS-SSA field office effort to ensure that all necessary information is collected when a person files a claims application, and we have a number of initiatives to enhance the medical community's understanding of our disability programs and to improve the timeliness of evidence supplied by treating sources.

In those States that are having difficulties of one type or another, we are intensifying our oversight efforts. We are also, in fiscal year 1992, going to be piloting new concepts, including ideas that have been introduced in your bill, Mr. Chairman, H.R. 1799. We will be piloting face-to-face interviews at the initial phase of the determination process, with one model eliminating the reconsideration step, as you have suggested.

In my experience at Social Security, I have seen that it is essential to pilot major administrative changes in order to find the best way to accomplish the desired outcome.

As to the timeliness of the disability process, the problems we face, increasing pending claims and longer processing times, are not going to be fixed overnight. The most important step that we urge you to help us with in the near term to deal with these increasing workloads is congressional approval of our full $4.532 billion budget request for fiscal year 1992. That is our administrative budget request. That appropriation will enable us to increase DDS funding by over 8.5 percent in fiscal 1992, and we believe that is a much needed increase, based on the increases in applications filed and claims pending.

I cannot urge this committee strongly enough to support the approval of that budget request. With that additional money, we will be better able to control the level of growth in the number of pending disability claims. Without it, we are going to see further deterioration in this area.

As always, Mr. Chairman, I appreciate the continued interest of yourself and the other members in this area, and I would be pleased to try and answer any questions and to work with you in making improvements to the program.

Thank you.

[The prepared statement follows:]

STATEMENT OF LOUIS D. ENOFF, PRINCIPAL DEPUTY COMMISSIONER SOCIAL SECURITY ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the subcommittee:

I am pleased to be here today to discuss approaches for improving the Social Security Administration's (SSA's) process for making decisions on disability claims and for streamlining the Agency's appeals procedures.

Program Overview

Mr. Chairman, it may be helpful to provide here a brief overview of the disability programs and the appeals process. This year SSA will adjudicate more than 2.6 million initial disability claims in administering the Social Security disability insurance (DI) program and the Supplemental Security Income (SSI) disability program. As you know, these programs provide essential income support for millions of people who cannot work. Many of these people are among our most vulnerable citizens.

Eligibility for disability benefits depends on two factors: the person must meet certain nonmedical criteria and must be disabled. SSA decides the first factor; generally, State disability determination services (DDSs)--or SSA's Office of Hearings and Appeals, if an appeal is taken--decide the second, following Federal rules and guidelines.

A local SSA field office helps the person file his or her claim and develops the nondisability factors for entitlement. For example, the claimant must have a certain amount of work covered under Social Security to qualify for Social Security benefits and must meet income and resource tests to qualify for SSI payments. If the individual does not meet the nonmedical requirements for entitlement, we deny the claim. If the technical requirements for entitlement appear to be met, the field office sends the medical portion of the file to the DDS.

In the State DDS, a team composed of a disability examiner and a physician (or sometimes a psychologist) makes the disability determination based on an evidentiary record that they build. The State DDS requests medical evidence from the treating physician(s) and other sources identified by the claimant. If that evidence is incomplete or conflicting, the disability examiner may request a consultative examination from the claimant's treating physician or another independent physician. As necessary, the examiner will also obtain evidence from the claimant's family, friends, or other observers which will help explain how the individual's impairment(s) affects his or her ability to work.

The team then considers all medical and other evidence to make the disability decision; if the claimant is not disabled, the DDS releases a denial notice to the claimant. Once the claimant is found disabled and any required review of the disability decision is completed, the medical portion of the file is returned to the field office. The field office completes payment actions after establishing or verifying the nondisability factors of entitlement.

Appeals Process

A person who is denied DI or SSI disability benefits (or whose benefits are terminated) may pursue appeal through three administrative levels and the Federal courts.

For claimants, the first administrative appeal level--reconsideration--is a de novo (fresh) review of the claims file performed by a State DDS doctor/examiner team who did not participate in the original decision. The new team considers any additional evidence and issues a reconsideration decision. In fiscal year (FY) 1990, the DDSs allowed about 17 percent of all claims appealed to the reconsideration level.

The second level of administrative appeal is a de novo hearing before an administrative law judge (ALJ), who conducts a new review of the claim and must ensure that the evidentiary record is complete.

The final administrative appeal level is the Appeals Council, which may grant, deny, or dismiss a request for review of the ALJ decision. It will grant review (generally a paper review) if there appears to be an abuse of discretion by the ALJ or if the ALJ decision contains an error of law, is not supported by substantial evidence, or involves a broad policy issue.

Our records show that about 70 percent of persons receiving benefits were allowed benefits at the initial application level and an additional 10 percent were allowed at the reconsideration level. Only about 20 percent of persons receiving benefits were allowed benefits at the ALJ hearing level. And, of course, some allowances occur at the Appeals Council and Federal court levels.

I will now address the issue of the accuracy of DDS decisions.

Accuracy of DDS Decisions

As the subcommittee has noted, criticism of the disability determination process has generally focused on the accuracy of DDS decisions and delays in SSA decisionmaking at all levels. Because ALJs frequently allow claims that were denied by a DDS initially and at the first level of appeal, it is commonly perceived that the DDS decision must have been inaccurate. As I will explain, this is generally not the case.

In general, the Federal/State disability determination process works well. For example, our most recent quality assurance data, for the quarter ending in March 1991, indicate that more than 94 percent of DDS initial determinations and reconsiderations were free of errors. Nevertheless, we are very concerned about the number of people whose claims have errors, and we are taking steps to improve this situation.

In terms of accuracy rates, the State DDSs range from about 90-98 percent in any given time period. The quality assurance data reflect the changes and mix in DDS workloads from month to month and, aside from workloads, the complexity of the cases being processed. Because of the many variables which could affect accuracy rates and because of the different characteristics of the States, it is not possible to isolate the particular factors that result in different accuracy rates among the States. I should emphasize that SSA monitors each State's DDS on an individual basis. When accuracy problems are identified in specific States, we intensify our efforts to improve those States' management capabilities.

ALJ Allowance Rates

Mr. Chairman, you asked why SSA disability determinations are so frequently allowed on appeal. Given the high DDS accuracy rate, one certainly might question why the ALJ allowance rate of DDS denials is so high when ALJs apply the same law as DDSs in determining disability. While there are no simple answers, I will try to explain why ALJs allow a substantial percentage of claims at the hearing level.

In many instances, cases reviewed by ALJs involve individuals who have significant impairments yet were found to be not disabled by the DDS because, based on medical and vocational factors, they were found to be capable of working. A change in their conditions or a change in perspective when making

evaluations of their functional capacity or vocational skills may frequently result in changing a denial to an allowance at the ALJ hearing level.

In addition, some cases are denied by the DDSs based on expected improvement in the claimants' conditions within 12 months of the onsets of their conditions, but improvement does not always occur.

ALJ decisions are, almost without exception, based on additional and different information from that available to the DDSs. In reality, the ALJ allowance is based on a substantially different case, because the ALJ is presented with new information that the DDS did not have. Thus, an ALJ decision may "allow" benefits but it does not necessarily "reverse" the DDS determination.

Two other factors may result in additional allowances at the ALJ level. First, the ALJ hearing is usually the first step of the adjudication process in which claimants may appear in person before the decisionmaker to explain their impairments and present witnesses who can attest to the effects of their impairments. Let me just mention here, however, the one notable exception that involves those beneficiaries who are found to be no longer disabled after a continuing disability review. If a review of the record indicates that an unfavorable decision should be issued, the DDS first offers the person a face-to-face hearing before a disability hearing officer.

Also, more than 80 percent of claimants are represented by an attorney or other individual at the hearing level. Because the representative assists the claimant in obtaining new evidence to support the case and explaining the effects of the impairment(s) to the ALJ at the hearing, representation often is an important part of a hearing. In sum, the DDSs are performing at a high level of accuracy, and the ALJ allowance rate, while high, reflects the fact that the ALJ is really making a new decision on what may be a substantially different case.

Rising ALJ Allowance Rate

Mr. Chairman, you asked why the ALJ allowance rate is rising.

I should first note that allowance rates for all adjudicative levels increased in FY 1990 compared to FY 1989. Although it is difficult to explain precisely why the ALJ allowance rate in particular is rising, it may be that feedback from the "higher levels" of review--the Appeals Council and the Federal courts--influences allowance rates at the ALJ level. I should point out that we have made a concerted effort in the last few years to ensure that the Appeals Council identifies cases that need further documentation. This heightened review has resulted in many more cases being remanded to the hearing level for new hearings. This allows claimants to present additional, updated evidence which, when coupled with changing medical conditions, results in more ALJ allowance decisions.

The Appeals Council effort to assure that cases are better documented has proved successful. In the second quarter of FY 1991, courts affirmed the SSA decision in 80 percent of cases heard.

H.R. 1799, Chairman Jacobs' Bill

Mr. Chairman, I would now like to comment briefly on your bill--H.R. 1799--to require initial face-to-face interviews for all applicants for disability benefits; eliminate the reconsideration step; and direct SSA to develop more comprehensive initial evidence of the claimant's condition.

Mr. Chairman, I think I can say that the goals of your legislation do not differ very much from the Agency's goals--to improve and streamline the disability process. Our differences appear to arise in just how we would go about meeting these goals, and we hope that this hearing and our continuing to work together will have positive results.

First, let me mention that there seems to be little difference between the intent of your bill and our current policies with regard to the development of all available medical evidence. We do think our decisionmaking can be improved by obtaining more information about the claimant's condition. We are already taking steps to ensure that all necessary information is obtained at the time an individual files for benefits. We are continuing our efforts to: ensure that the DDS secures complete and accurate medical evidence, enhance the quality of medical evidence, and work with medical experts and disability experts to make sure that our disability criteria are complete and up to date.

Mr. Chairman, we think the proposals in your bill are very good ones, and we want to consider them carefully. We have learned that the experience we gain in piloting major administrative changes is very valuable--we would even say, essential--in deciding on the best way to implement a change. Therefore, we want to pilot various approaches for implementing face-to-face interviews to see what will work best. We plan to begin piloting face-to-face interviews in FY 1992. I will discuss our plans for face-to-face interviews shortly, but I might mention now that one of the face-to-face models we plan to pilot would eliminate the reconsideration step, as you suggest in your bill.

This approach of focusing on the initial stages of the disability determination process has considerable support from outside groups. As you know, Mr. Chairman, questions often have been raised about restructuring the entire disability determination process, including the hearings and appeals levels. In response to these suggestions, we sought input from both internal and external sources, such as the Disability Advisory Committee and the Administrative Conference of the United States. The preponderance of the recommendations we received pertained to the early stages of the disability determination process.

Personal Appearance Demonstrations (PAD) Report

Mr. Chairman, before I talk about our pilots for face-to-face interviews, I want to explain to you in a very frank way the reasons why the report on the PAD projects which was due in December 1986 is so late. I also want to tell you about some flaws in the study that resulted in unreliable data. Regrettably, everything that could go wrong with the PAD projects did in fact happen.

First, the startup of the project was delayed because of difficulty in selecting States to participate. Some States which were suited for the project declined to participate or withdrew. Some other states which were willing to participate were not well suited for the demonstration model. Second, there were problems with data collection, including the use of inconsistent case selection criteria among the States.

Finally, the completion of the project was delayed because final data could not be compiled on project cases that were appealed by the claimant until the ALJ level of appeal was completed.

In spite of the above problems, we did gain some very general information that we believe is useful.

- o The public felt better about the personal contact interview than the traditional paper reconsideration review.
- o Reduced processing time resulted at the DDS level and through the ALJ level for demonstration cases.
- o Greater numbers of allowances occurred earlier in the adjudicative process for those individuals in the demonstration groups.
- o Accuracy for demonstration group cases was comparable to the national accuracy rate, with proportionally better documentation in demonstration cases.

The final PAD report is now in the latter stages of the clearance process and is expected to be released in the near future.

Face-to-Face Interview

Mr. Chairman, we do believe that providing a face-to-face interview before an initial decision has significant potential to improve the quality of disability decisions. The preliminary results of the PAD study also indicate that a face-to-face interview has the potential to improve the determination process. However, we think we must move carefully in implementing such a major change in the disability process.

Both the Inspector General for the Department of Health and Human Services and the General Accounting Office (GAO) expressed concerns in this area. A January 1990 management advisory report by the Inspector General stated that personal interviews between the claimant and the decisionmaker have been viewed positively by claimants. However, that report also indicated that DDS management expressed concerns about implementation of face-to-face interviews, because it would require significantly more personnel and other resources.

Also, GAO, in an April 1989 report to the Chairman of this subcommittee entitled "Social Security: Selective Face-to-Face Interviews with Disability Claimants Could Reduce Appeals," cautioned that full implementation--i.e., interviewing every disability claimant--would be impractical because of the large volume of cases handled by State DDSs.

We want to be candid with you, Mr. Chairman. No matter what the advantages or disadvantages of face-to-face interviews, they will be costly in both resources and time, and we need to wrestle with that problem. Given the limitation in funding under the domestic discretionary program cap established under the Budget Enforcement Act, we need to fully evaluate the potential for high costs for the face-to-face interviews to ensure adequate funding will be available to cover the cost of national implementation. We are concerned about this being a costly initiative.

For these reasons, we intend to move with caution to pilot a face-to-face interview process at the local level--before making an initial determination or when a reconsideration is requested. We plan to begin the pilots before the end of FY 1992.

Ensuring that DDSs Secure Complete Evidence

Mr. Chairman, you asked whether SSA decisionmaking can be improved by expanding the information on which decisions are based and, if so, what additional information should be gathered.

While, as I previously indicated, the DDS accuracy rate is over 94 percent, we think that our decisionmaking may be improved by enhanced data gathering. We have already started a cooperative DDS/SSA field office effort to immediately strengthen the claims intake process by taking appropriate steps to ensure that all necessary information is obtained at the time an individual files an application for disability benefits.

Quality review teams, composed of field office and DDS representatives and supported by regional office staff, have begun an initial review of samples of disability development forms from every field office. This review will identify and correct deficiencies which delay processing or require claimant recontact. Based upon the findings, individualized action plans, designed to improve development quality, will be established for each field office.

We also plan to conduct a followup review next year to evaluate the degree of improvement and assess which remedial actions--for example, desk guides, written reminders, specialized training, etc.--proved to be most productive.

These efforts will ensure that the DDS has complete, accurate, and necessary information earlier in the claims development process. Improved claims intake will eliminate unnecessary DDS actions, accelerate the development process, and provide better service to the public.

Enhancing the Quality of Medical Evidence

Recommendations from the Disability Advisory Committee and others stressed not only improving claims intake but also expanding our efforts to increase physician understanding of disability eligibility requirements. We have undertaken several initiatives to enhance the medical community's understanding of our disability programs and to improve the quality and timeliness of the evidence supplied by treating sources.

As you know, in disability decisionmaking it is required by law that we obtain the claimant's complete medical history for at least the last 12 months for any case in which a determination is made that the claimant is not under a disability. In addition, we are required to make every reasonable effort to obtain medical evidence from treating sources before requesting a consultative examination. Treating source evidence is especially important because these medical professionals are most likely to provide a detailed, longitudinal picture of the claimant's medical impairment(s).

To help achieve improvement in this area, we are conducting continuing medical education courses on the DI and SSI disability programs at conventions of national medical organizations. We are also conducting national meetings of State and regional SSA medical relations staff to share information and best practices.

In addition, we have established a cooperative relationship with the Department of Veterans Affairs to assist in securing medical evidence of record, and plans are under way to develop a similar relationship with Public Health Service facilities such as the Indian Health Service. We are also working to forge more productive relationships between DDSs and State Maternal and Child Health Block Grant programs to improve, among other things, our ability to secure medical evidence on children.

Ensuring Disability Criteria Are Complete/Up to Date

We are also working with experts from various disciplines to review medical policies and procedures. This is helping us to update the evaluation criteria contained in regulations for both

adults and children who have cardiovascular, musculoskeletal, mental, respiratory, and other impairments. This expert advice has also helped us to make other revisions, including those involving the general criteria under which we evaluate childhood disability.

Mr. Chairman, you noted that some critics have cited DDS "insularity" as a cause of decisional errors. You asked whether this is a widespread problem and, if so, whether establishment of DDS advisory groups composed of medical and legal experts, government representatives, and advocates for the disabled would improve the accuracy of disability decisions.

Clearly, disability evaluation is a complex task requiring sophisticated professional expertise. In developing disability evaluation policies and procedures, SSA consults with medical, legal, and other experts, other government agencies, and private nonprofit agencies, including advocates. These diverse perspectives are essential in formulating equitable policies and procedures to administer the disability provisions of the Social Security Act.

Because the disability program is a national program, it is important that our interaction with experts and others on policy and procedural issues occur on a national level. For example, the Disability Advisory Committee recently provided us with beneficial information and comments regarding how to improve our disability decisionmaking and appeals processes. On the other hand, it is certainly appropriate and advantageous for State DDSs to interact with the local professional community and advocates, and we encourage such dialogue. All DDSs conduct professional relations activity to inform the community about our program requirements and evidence needs. These efforts do result in better documentation of claims and improved decisions. As a result, we do not believe that a formal advisory structure should be mandated.

I would now like to address the timeliness of disability decisions.

Timeliness of Decisions

Timeliness of DDS decisions has always been a concern at SSA. For the quarter ending December 1990, the average time to process a DI initial claim to completion was almost 84 days. For the same period, average processing time for a DI reconsideration was 66 days and for a hearing, 215 days. All of these figures reflect increases from previous quarters' processing times.

One of the major factors recently influencing the timeliness of disability decisionmaking is the significant rise in disability claims filed.

In the past year, SSA has seen a dramatic increase in the numbers of SSI and Social Security disability claims filed. This recent growth results from a number of factors. Part of the increase in claims receipts results from our outreach program to reach needy people who were not aware of their potential eligibility for benefits. Another factor is the downturn in the economy.

At the end of November 1990, 392,000 initial disability claims were pending in the DDSs, compared with 301,000 one year earlier--an increase of more than 30 percent.

In SSA's FY 1992 budget request as submitted to the Congress in January 1991, we assumed that the number of initial disability claims pending in the DDSs would grow from about 385,000 at the end of FY 1990 to about 700,000 by the end of FY 1992, based on

budgeted disability claims receipts and budgeted resources to process disability workloads. This would represent 20 weeks of work on hand and an increase of more than 80 percent from the claims pending at the end of FY 1990.

The problem of increased pendings and processing times is not one that can be fixed overnight. DDS funding from FY 1988 - 1990 was held level at about $750 million, which represented a decrease in real terms. This, combined with an increasing number of cases coming in the door, added complexity of cases, and increased emphasis on quality, has added significantly to our processing times. Thus, one of our top priorities has been to increase funding to process these workloads. The President has requested $4,532 million for SSA administrative expenses for FY 1992, and of this amount, funds budgeted for the DDSs would increase by 8.5 percent, from $800 million in FY 1991 to $868 million in FY 1992. The first substantial budgeted increase for the DDSs since FY 1988 occurred in FY 1991 (6 percent), and the President's FY 1992 request would be another substantial increase.

As you know, Mr. Chairman, we received $100 million from the contingency reserve for FY 1991 in March 1991. Most of these funds will be allocated to State DDSs and SSA components for processing disability workloads. We now estimate that we will be able to process about 100,000 additional disability determinations this year.

These additional resources will help SSA and the DDSs control the level of growth in the number of pending disability claims this year. However, despite this increased funding effort, disability processing times and pending claims levels are expected to increase. We will continue to manage workloads, monitor processing times, and keep the Congress informed of any significant changes in the level of service that SSA can provide as we begin to recover our ability to process disability cases on a more timely basis. However, if the President's request for $4,532 million for SSA's administrative expenses for FY 1992 is not enacted, further deterioration in this area will likely occur.

Conclusion

In closing, Mr. Chairman, I would like to thank the subcommittee for the opportunity to address these important issues of mutual concern. You may be assured that SSA is fully committed to developing and maintaining a fair, accurate, and timely disability determination process to provide the best possible service to Americans with disabilities. Although our national indicators suggest that our management in the disability area is moving the program in the right direction, we must emphasize that the Agency has an obligation to monitor the management of each State's DDS. When DDS management problems are identified in particular States, we are intensifying our efforts to improve their management capabilities. We are also committed to continuing strong Federal leadership to ensure effective delivery of the disability programs.

Chairman JACOBS. Thank you very much.

Mr. Bunning.

Mr. BUNNING. Thank you, Mr. Chairman.

You have heard the testimony of Ms. Griffin and Ms. Rangel, two women who preceded you. Can you tell me, are they both in the same region, as far as Social Security? I mean are they treated by the same group of——

Mr. ENOFF. Mr. Bunning, the disability determinations are made by the State Disability Determination Service, so they are in——

Mr. BUNNING. So, they are in different——

Mr. ENOFF. One is in Maryland, I believe, and one is in Virginia, as I heard their testimony. I did not have any information about their claims prior to today.

Mr. BUNNING. I do not want to talk about their claims. I just want to talk about the two different States in the handling of the problems.

Mr. ENOFF. Both of those States, I might say, Mr. Bunning, are very good States in terms of processing and overall quality. Now, I am not speaking to the individual claims, but their overall processing and quality is in the higher bracket.

Mr. BUNNING. Then it is the process itself that is flawed?

Mr. ENOFF. Again, I cannot speak to individual situations—what I heard was that some information, which was not obtained at the initial stage, was obtained later, that there were delays. I do not know why those delays were caused. I would be pleased to look at those individual claims, if the committee would supply the information.

Mr. BUNNING. I thought by asking if each State handles their claims separately, it becomes obvious that it is not one State over another. They both had the same problems in two different States, so I assume that the problems are not only in Maryland and/or Virginia, but in Kentucky and in Ohio and in California.

Mr. ENOFF. The situation of not having complete evidence can happen in any State, that is correct. The States follow Federal guidelines, and the process should be essentially the same.

Mr. BUNNING. Let me ask you about the specific bill that Chairman Jacobs has introduced. If we eliminate the second step in the program and get from the initial decision right to the hearing process, do you believe that is a legitimate solution to the waiting times that the applicants are having right now?

Mr. ENOFF. Well, if we did that right now, Mr. Bunning, if you look back to that chart—and that is one of the reasons I referred to that chart—5 of the 100 people illustrated by the chart—about 10 percent of the people who come on the rolls—get approved at the reconsideration stage, which is much faster than the hearing stage would be.

Now, 26 are denied. Of those, 17 go on to appeal to an administrative law judge, so 9 of those persons do not have a hearing presently. Now, we are concerned about those 9, and we have done some research about what happens with those 9, but I cannot give you valid information.

What would happen is the workload at the hearing level would more than double.

Mr. BUNNING. We understand that.

Mr. ENOFF. And that is a concern.

Mr. BUNNING. Well, it is a concern only if you are worried about not getting the results. We want to make sure that the people that deserve——

Mr. ENOFF. Absolutely, we agree. We want to get benefits to those eligible as quickly as possible. We are in agreement.

Mr. BUNNING. Well, improving the means to the end is the most important thing that we can do, then. I am asking you specifically, if we eliminate the second phase, will we get a quicker result and get a more just result by the hearing process, than we will at the second level. It looks to me like the second level is put in as a means of holding back——

Mr. ENOFF. Again, what I would say is that the 10 percent that are allowed at that level is one-half of those that are allowed at the administrative law judge level.

Mr. BUNNING. OK.

Mr. ENOFF. The other situation that occurs is that there is a question that arises—and I do not know whether Chairman Jacobs is proposing in his bill that evidentiary hearings be conducted at the Federal or State level, I just am not sure, Mr. Chairman, of that. Currently, a hearing is held at the ALJ Federal level, and the reconsideration decision is made at the State level.

The pilots that we will do next year—and these are not tests, but pilots to determine the most effective, efficient process to implement face-to-face interviews—would use Federal employees in one instance and use State employees in another instance. We have a situation at the DDSs where many of them are not decentralized and they do not have disability examiners located in the areas where it would be necessary to hold these hearings. The pilots will help us determine the best way of implementing a face-to-face interview process. In fact, we might end up recommending that we use Federal employees in one situation and State employees in another situation.

Chairman JACOBS. If the gentleman will yield for a clarification——

Mr. BUNNING. Yes.

Chairman JACOBS [continuing]. I believe the point you make, the answer to it is that it is left to your discretion by the way the bill is drawn.

Mr. ENOFF. I just did not remember that.

Mr. BUNNING. I do not think Ms. Griffin or Ms. Rangel care about the process, only the fact that they get benefits if they are entitled to them. I think that everybody, who applies for benefits under the situation that we have now, seems to be delayed in some manner, whether it be in Virginia or Maryland or wherever it may be.

Mr. ENOFF. I absolutely agree that we want to eliminate every delay.

Mr. BUNNING. What I am asking you, and I ask you again, do you think Mr. Jacobs' bill is a means to that end?

Mr. ENOFF. As I indicated in my testimony, Mr. Bunning, I would want to carefully pilot the process. I think we are going in the same direction. We need to carefully look at the exact way of

doing it, and we need to work with the States in developing the best process.

Mr. BUNNING. Well, if we are going to——

Mr. ENOFF. We are going in the same direction.

Mr. BUNNING. If we are going to approve or if you would like us to approve the amount of money you have requested, does that include the pilot or does that include any additional dollars for something like Chairman Jacobs' bill?

Mr. ENOFF. We have included money in our budget to do face-to-face pilots beginning in fiscal year 1992.

Mr. BUNNING. Well, we are going to have an awful lot of people still waiting, then, are we not?

Mr. ENOFF. Yes, sir.

Mr. BUNNING. Even if we approve your requested budget?

Mr. ENOFF. If you approve our requested budget, we will bring down the pending workloads and processing times.

We just received $100 million in contingency funds, and that will allow us to process 100,000 additional claims. Otherwise those 100,000 claims would be pending. We have had a tremendous increase in the number of applications filed.

Mr. BUNNING. I am sorry, this subcommittee and others on the Ways and Means Committee urged OMB to release that money a long time ago.

Mr. ENOFF. We appreciate that, and I am not complaining to this committee about that. I am simply saying that with the regular workload and the *Zebley* claims we are going to be asking the State DDSs to take on a tremendous workload in fiscal year 1992. I believe they are prepared to do that.

We had an unanticipated increase of 10 percent over what we budgeted. We have adjusted our 1992 budget by an additional 8 percent; however, we are seeing a very large unanticipated increase in workload. We want to process that workload as quickly as we can, and as carefully as we can, and that involves relationships with the States and relationships with the doctors. We have to get the information that we need to decide a claim at the earliest possible time.

Mr. BUNNING. I just want to make sure that the people who apply for benefits are told all of the information that is needed at the very beginning, so they know what is expected. If they need legal help, tell them there are available services whatever it might be.

Mr. ENOFF. We tell them it is available. Our employees assist them in getting information, but sometimes additional medical information is necessary.

Mr. BUNNING. Thank you, Mr. Chairman.

Chairman JACOBS. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

One of the witnesses who will follow you will testify that SSA only pays for physicians that they contract with, not with the treating physician. Is that true?

Mr. ENOFF. No, our policy on consulting physicians gives preference to the treating physician, if the treating physician is able to do the examination that is required. That was the case several

years ago, but our practice has changed and our preference goes to the treating physicians.

Mr. MCDERMOTT. How do you decide who can do the tests required or whatever?

Mr. ENOFF. That is a medical determination that the doctor——

Mr. MCDERMOTT. Made by a physician in the department?

Mr. ENOFF. Yes, in the State agency.

Mr. MCDERMOTT. In the DDS?

Mr. ENOFF. That is correct. The decisions on these claims are made by a team, which includes the disability examiner and a physician with the pertinent background. If additional evidence was needed, the medical team would determine the specialty or special test that was needed.

First of all, we gather all treating physician information up front. You have asked whether we go back to the treating source or someone else if a consultative examination is needed. If the treating source has the expertise, we go to him.

Mr. MCDERMOTT. So, in the cases we heard here before, if the recommendation was made by the general practitioner and you wanted to get further tests, you would go to your own orthopaedic surgeon to find out if somebody had back problems sufficient to require disability payments?

Mr. ENOFF. When you say "your own," do you mean the individual's own physician or our own?

Mr. MCDERMOTT. Somebody that is chosen by the agency.

Mr. ENOFF. When we request consultative examinations, we contract for physician services. These are not federally employed physicians. We would go to the treating——

Mr. MCDERMOTT. That is not Federal Government, but they are contracted with?

Mr. ENOFF. Yes.

Mr. MCDERMOTT. They usually are favorable to your position, however. [Laughter.]

Mr. ENOFF. Well, I would not say that. We would go to the treating source of that person if he is capable of doing it, that is the answer.

Mr. MCDERMOTT. Let me ask you another question here, and that is you have a self-help policy, you hand them these forms, apparently. Some of the witnesses who are going to testify after you leave, the problem is that, since you are up here early, I have got to read their testimony and then kind of ask you the question before you get out of here.

The suggestion that you hand them the forms and ask them to fill them out, it strikes me that people who are the most vulnerable, those people who are illiterate, those people who do not speak English well, those people who have the most physical, emotional and whatever kind of difficulty, are the ones most likely to fill them out improperly and wind up in the bottom of the heap, either rejected or sent back through the loop over and over again for more information or until they fill the form out right.

Mr. ENOFF. The person who may have difficulty in completing the form should not be handed the form and asked to fill it out. That person should be given assistance by the Social Security rep-

resentative who takes the application, whether it is over the telephone or in person.

Mr. McDERMOTT. Do you think you can make that decision over the phone?

Mr. ENOFF. What we found, Mr. McDermott, is interesting. In some situations a person would rather be at home with other people there, talking on the phone to the claims representative. Claimants often have medical information available at home which they can use. Sometimes that happens.

However, we think that face-to-face contact is a preferable approach. Oftentimes a decision can be made based on the telephone application and evidence submitted by the treating physician. In 60 to 70 percent of the claims approved at the initial stage, evidence from the treating physician is sufficient.

Mr. McDERMOTT. How is it decided, whether it is by phone or in person?

Mr. ENOFF. It is the choice of the individual.

Mr. McDERMOTT. Choice of the individual?

Mr. ENOFF. Sure, choice of the claimant.

Mr. McDERMOTT. In other words, if they call in and say I want to make a claim, the offer is made over the phone, do you want to give the information over the phone, or would you like to make an appointment to come into the office?

Mr. ENOFF. Yes, that is correct, they have the option. If they want us to send the application to them so they can complete it, we mail it to them. If they want to handle it over the phone, they can do that. If they want to come in and have us assist them in the office, they can do that.

Oftentimes, I might add, DDSs might call claimants and ask them for further information.

They ask about any treatment the person received within the last year, any kind, anywhere. But I must tell you that we do have situations, Mr. McDermott—and particularly since you said you were familiar with SSI claims—where there is not a treating physician, but there may be evidence from a clinic or other sources like that, we would request those records. If there are no medical records readily available, we may have to get a consultative examination.

We have several initiatives under way, working with the DDSs, to do outreach in those areas. DDS employees work with other State entities to ensure that the applicant can get to a consultative examination or can get the evidence that is available from a treating source.

Mr. McDERMOTT. As I listen to you, if I were sitting out in the audience listening to that, it would sound like the most user-friendly insurance company in the world, and I know that there will be testimony that you are going to have 820,000 backlog cases by September. I do not know if you agree with that number, but that is testimony that follows you.

Mr. ENOFF. I do not know where that number comes from, but with the contingency money, I would hope that our pending claims are going to be much less than 820,000. I can give you our projection. I want to say that it is a user-friendly system that we have. The Commissioner's first call is service, and we want it to be user-

friendly, and we want to give the option to the individual who applies.

Mr. MCDERMOTT. You have 435 congressional district offices that would question that statement.

Mr. ENOFF. I think that it would——

Mr. MCDERMOTT. We spend more time on Social Security claims in my office in Seattle than any other single issue—well, no, I guess immigration, you probably run neck-and-neck with immigration.

Mr. ENOFF. I would say, Mr. McDermott, that with the volume of claims that you are talking about, you are going to have some claims that are delayed, but I would submit to you that we handle about 50 times more claims than the immigration office handles.

Mr. MCDERMOTT. You are saying you do not need anything but more money, then?

Mr. ENOFF. I did not say that. I did not say that. I think the process needs a good examination. We welcome that examination and want to work with you in examining that process. We need more money, but more money is not the answer to all of those questions. This is a very complex program.

Mr. MCDERMOTT. If it's working so well and nobody is—it sounds like all you need is more people to make it work and get rid of the backlog.

Mr. ENOFF. If you got that impression from what I said, I want to make it perfectly clear, the answer is not only more money. We need our full budget request, yes, and we need it timely, yes. We need to make some adjustments to the system, but I think we need to be careful when we make those adjustments. We have all experienced changes in this program that were made without careful, thorough, prudent, investigation.

And we do not want to make changes that are done, without testing them in a pilot.

Mr. MCDERMOTT. We will try and help you out.

Mr. ENOFF. We appreciate that.

Mr. MCDERMOTT. Thank you.

Chairman JACOBS. Mr. Pickle.

Mr. PICKLE. Mr. Enoff, it is good to see you again and to have your testimony.

I think there is a general agreement on everyone's part that the quicker we can get more evidence, up front, at the initial stage or at some appropriate stage, the better off we are.

Now, you have recommended that we explore that more thoroughly and have a pilot test of it. Now, you were supposed to have a pilot test back in 1986 or thereabouts, and you point out to us in your testimony that you had all kinds of problems. Some States did not want it, and some States did not have the money, and other States would not have been an appropriate State, and you had all kinds of problems.

About all you ended up with after that pilot test was some kind of a study, and you made certain conclusions from it.

Mr. ENOFF. That was not a pilot, Mr. Pickle. You are right, it was a study and it was a disaster in terms of the results, because some of the data were lost. We have concluded that we do not want to test any more. We are talking about a pilot of the process.

Mr. PICKLE. Well, whether you tested it or piloted it, it seems to me that your track record in this area has been a very poor one. You started out 5 or 6 years ago and you concluded with nothing except some summaries. Perhaps there is a very good reason why you did not do them, but you did not.

Now, my first question would be, if you were to conduct a pilot program now, on this subject, how long would it take you to conduct it, and what would be the approximate cost?

Mr. ENOFF. Let me say that when you do a pilot or a test in this area, because of the timespan between the initial application and the total appeals process, it is going to take more than a year to do that pilot in order to get the necessary data, from the initial level through the appeal stages. So I would say it is probably going to take at least a couple of years to do that.

Mr. PICKLE. Well, are you saying by the end of 1992 or the middle of 1993?

Mr. ENOFF. I am saying, Mr. Pickle, that we were delayed in these pilots, because of this workload. I will tell you, we had a delay in getting the contingency funding and we wanted to start those pilots this year. We are not going to be able to start them until either the very end of this year or the beginning of 1992, so I would say 2 years from 1992.

Now, that does not mean that we have to wait until all those pilots are done to implement changes in the process, if we find something is working. For instance, I just saw yesterday the results of a pilot we did in one region on prehearing conferences. This is where a staff attorney in the ALJs office sits down with the claimant's representative and the claimant before a hearing and goes over all the evidence; the prehearing conference has a tremendous potential.

We found that there was an opportunity to make many favorable decisions right there on that record, without a hearing. That cut down the process tremendously, and we think it has a good potential.

You know, when we get into the situation of scheduling hearings with representatives, there are delays that come into that process through no one's intentional fault. There are a number of things that we are working on that can improve that process, and we need to continue those while we explore others. You are absolutely right, however; the front end is essential.

I did not get to say to Mr. McDermott, but I can elaborate a little more on what we are doing with the review of initial applications. A joint team from the DDS and the district office is working to ensure that as much evidence as possible is gathered at the very first stage; that is critical.

Mr. PICKLE. Mr. Enoff, let me make a personal observation. It would be very helpful and very useful, if we had a pilot test and we knew actually what would happen in one of these if we changed the program. But if we wait 2 years, I rather doubt this committee is going to be willing to postpone corrections in the long number of months it takes to consider a Social Security disability claim.

Your track record has not been very good. I do not know that we would not be faced with the same problem this time as we did 3 or 4 years ago when you were having test problems. I hear all of your

explanation of why, and I do not know why you would not have the same problems again. So, I approach the question of a pilot test with some apprehension.

I think we ought to realize, though, that if we moved up the initial stage for the face-to-face, that is going to cost us a lot more money, I would think.

Mr. ENOFF. Yes.

Mr. PICKLE. That was one of the considerations in 1983 and 1984 that we did not do that, and it will cost us, but it will also cut down the long delays in making decisions.

Your decision process now goes anywhere from 6 to 7 months, almost at a minimum, up to 2 years, and that is a horrendous record, and that is our problem.

Mr. ENOFF. I think the chairman made the point very well earlier that cost is not the only consideration here, it is not the primary consideration. Getting the right decision as quickly as we can is our goal.

The Commissioner has instituted a whole series of initiatives at getting better, faster decisions at the first stage, at the DDS. I guess what I am saying, Mr. Pickle, is we do not want to brush those aside, because if we are going to say that of the persons who are allowed at the ALJ level, there are—I am pointing back to that chart—there are 20 percent who are allowed at the ALJ level, the studies that I have seen indicate that maybe up to one-third of those could have been allowed earlier. So, maybe 5 percent of the persons who come on the rolls could have been allowed earlier. I believe we can get at that in a number of ways, and I believe some of the initiatives that the Commissioner has launched will do that.

I am not suggesting that we should not make any change, but if we were to immediately eliminate the reconsideration stage, we would probably have to hire 200 or 300 administrative law judges and train them and get them into the process very quickly. We have 115 coming on duty this month.

Mr. PICKLE. Mr. Enoff, we are exceeding our time and I do not want to do that.

Mr. ENOFF. I am sorry.

Mr. PICKLE. I hear more excuses than I do performance here in this area.

Mr. ENOFF. Well, I do not mean to give you excuses.

Mr. PICKLE. I think we have got this problem, because disability has not handled these cases faster and better, or we would not be holding this hearing today. I rather believe that, if we just delay it, I do not know that we will not face the same situation.

Mr. Chairman, I want to make this observation: Way back—and Mr. Archer testified earlier this morning—we even considered the possibility of a Social Security Court, trying to find some way to move faster and perhaps more efficiently, and it is still a good possibility.

I cannot help but observe that this morning I see in the audience one member of our staff from 1981 and 1982 who was advocating that Social Security Court, and that was Mr. Fred Arner, the fellow with the little beard back there, and he has been working on this problem as long as Arthur Flemming or Robert Ball. I just want to recognize Fred's attendance here this morning.

Mr. Chairman, I just simply say that we need to make some changes and it is going to cost us, but if we can cut down the time, we had better do it, and I do not know that we need to wait 2 years for another study.

Thank you.

Chairman JACOBS. Thank you.

Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Enoff, it is always a pleasure to have you before the committee, and I personally believe that much of the problems that we are confronting today has been the neglect with providing adequate resources over the last many years to your agency in order to process the claims, and we are paying the cost of that today in the system that we have, by not giving adequate resources to your agency.

I really must differ with your assessment of where we are today. It seems to me that our objective is that everyone is treated equally and fairly that applies for benefits under the Social Security Administration, we want everybody to be treated in a similar type of way, and I do not see that today by the figures that you present.

I look at your figures, and I see a very bad record, not one that you defend that only 20 percent of the people have to go to the ALJ judges in order to get benefits. I wonder how many people have dropped out, have not even gone that far, been so frustrated by the process, have come to the conclusion that it is just not worth the time, that it will not be successful. They may live in a jurisdiction where it is impossible to get legal help, because of the overburdened system for poor people to get legal aid.

We have to have a better way, in order that people's initial determinations are treated better, and if they need to go to an appeal, that that is handled in a more streamlined way. A 60-percent reversal, I know you do not say it is a reversal, but it is. It is people who have been denied for a long period of time benefits, because their information was not complete, for whatever reasons, or circumstances were such, or someone did not look at their file properly.

The circumstances that Ms. Griffin said, for example, in her case, where a reversal was made on the file, without even a hearing, suggests to us that the system is not right.

One of the other hats I wear, I chair the Maryland Legal Services Corporation, and if you are going to refer every person who seeks disability benefits to legal aid, they are not going to get handled. They do not have enough lawyers to handle it. I am wondering whether you are going to be recommending to the President that we increase the budget to the Legal Services Corporation of this country, in order to provide necessary legal aid to the people that are going to need it.

The system should not have to require all of that. And what worries me more is that I am looking at your statement, where you say that in the fiscal year 1992 budget request submitted to the Congress in January of 1991, we assume that the number of initial disability claims pending will grow from 385,000 to 700,000 by the end of fiscal year 1992. It does not look like we are making any progress.

Mr. ENOFF. I would say to you that, no, we do not want everyone who applies for benefits to have to seek the help of an attorney. The point I was making with the chart is that 80 percent of those people probably do not have any attorney, they get the benefits at the first stage. I am not suggesting that 20 percent is a small figure. I would hope that none of them would have to have legal help, that we could assist them, to the extent we can.

In fact, I must disagree with you, when you say that it is a reversal. I would say to you that the majority of the claims that the administrative law judge decides to allow are not a reversal of the prior claim, and we can look at those claims and see what happens there.

Now, the reasons vary. Sometimes there is new evidence, sometimes the situation worsens. In 10 percent of those situations. Mr. Cardin, it is an impairment that was not even talked about at the initial stage. Now, we need to get better information somehow on those cases, I agree with you. I do not disagree at all.

The other point that you make, that the number of initial disability claims pending will increase to 700,000, has been superseded. Because we now have some money from the contingency reserve, it is going to be lower than 700,000. We cannot talk just about numbers there, and I do not mean to minimize it. It is a growing pending caseload. But because we are going to be hiring in the State DDSs, we should look at another kind of pending number, what we call weeks work pending. We like to have 8 to 10 weeks work pending as a pipeline to keep all of the process working. We are up to 11 or 12. We were looking at going to 15 or 16. With the contingency and the supplemental, we believe we can keep it down under 15, down around the 13 level, still not ideal.

So, I agree with you, we do need to ensure that we get the funding that we have asked for in 1992. We appreciate the supplemental and the contingency and believe we can make some progress, but I do not want to say to you that if I came back here in 1 year, the pending would have disappeared.

Mr. CARDIN. I am curious as to whether you have done any followup as to what has happened with the people who have been denied at the first level, and have not sought a review. Have you done any samples, to see how many people entitled have not even gone forward? Or how many people perhaps have died and, therefore, their claims might look a little bit better from your statistical point of view, because they did not live long enough in order to get through our system?

Mr. ENOFF. We have done some sampling. I cannot say that I have a statistically valid answer, but we have done some sample work. GAO did a sample, also, a couple of years ago. We have just begun a sample and, in looking at that, about half of the people who were denied do definitely go back to work. Of the other half, some subsequently file another new application and are allowed.

I can give you the data that we have. I do not have it with me, but I can supply that data. As I say, it is not a statistically valid sample. It is the first probe that we have done and it has just been done this year. We would be glad to supply that to you.

Mr. CARDIN. I would like to have that information.

[The information referred to above follows:]

A sample study of initial disability claims denied in 1986 showed that of those claimants denied disability benefits and who did not appeal the denial decision, 37 percent returned to work; 35 percent filed a new application and were awarded retirement, survivor's, or disability insurance benefits; 6 percent filed a new application but were denied benefits; and 22 percent did not file a new application for benefits.

Mr. ENOFF. We are very concerned about that group because, as you say, this is a group that may not have access to assistance, and we do not want that to happen.

Mr. CARDIN. By your own figures, you are telling me now that 1 out of 3 or 1 out of 4 people getting benefits under the appeals process should have originally been approved. That is what your figures are saying?

Mr. ENOFF. I say it could be up to one-third.

Mr. CARDIN. This is shocking and unacceptable.

Mr. ENOFF. It is not acceptable, and that is why we have put our effort on the initial stage—getting the best evidence as soon as we can and trying to make sure that all the evidence is there and is reviewed.

The Commissioner has just directed that we also ensure that we have a plan to take over a State's disability determination function if the State's performance goes down and does not come back up. We cannot accept that level of performance. I agree with you.

Mr. CARDIN. Let us develop a strategy to improve it.

Mr. ENOFF. Sure.

Mr. CARDIN. Thank you, Mr. Chairman.

Chairman JACOBS. Lou, the thing I like about not asking the questions initially is that the other members usually ask all of my questions, and we could go to lunch sooner, but that is not going to happen today.

CBO, I believe, is going to testify that if this legislation were enacted, over a 5-year period the cost would be $7.2 billion.

Mr. ENOFF. I have not seen that figure.

Chairman JACOBS. Well, this is for your edification.

Mr. ENOFF. OK.

Chairman JACOBS. I am also told that, of that $7.2 billion, they estimate $300 million will be increased administrative costs, thus, $6.9 billion would be additional benefits paid.

Mr. ENOFF. Something sounds wrong with that number to me, and I would like to see those estimates.

Chairman JACOBS. I am told that they are nonpartisan. If that is true, then somewhere along the line, in the opinion of the Congressional Budget Office study, deserving people are not getting their just deserts, and I think—Mr. Cardin hit it pretty well, so I will just touch on it lightly, and you mentioned yourself. That is that about 15 out of your 100 examples do not go back to work. They are some place and something is happening. Is that not about right, you said about half of those——

Mr. ENOFF. Do not appeal.

Chairman JACOBS. Yes.

Mr. ENOFF. Do go back to work.

Chairman JACOBS. Do go back to work, and the other half would be about 15 percent of those who apply, they are some place and something is happening, and I have an idea that they may well be

somewhere around 6.9 billion dollars' worth of benefits which they paid for and did not get.

Mr. ENOFF. I do not know.

Chairman JACOBS. Given that premise.

Mr. ENOFF. I would be pleased to comment on CBO's study.

Chairman JACOBS. Start your car and drive to Baltimore. Thank you very much.

Mr. ENOFF. Thank you, sir.

Chairman JACOBS. The General Accounting Office is represented today by Joseph Delfico, and we welcome you back for your testimony, sir.

STATEMENT OF JOSEPH F. DELFICO, DIRECTOR, INCOME SECURITY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY BARRY TICE, ASSISTANT DIRECTOR, DISABILITY PROGRAMS

Mr. DELFICO. Mr. Chairman, with me today is Mr. Barry Tice, who is the Assistant Director in charge of our disability program work.

With your permission, I would like to submit the full testimony for the record and present a brief 5-minute summary for you.

We are pleased to be here today to discuss efforts to improve the initial decisionmaking on Social Security disability claims, and to explore reasons why many claims are only allowed after hearings by administrative law judges.

My remarks will address concerns we have about disability cases, processing accuracy and timeliness, and the impact budget constraints placed on State disability determination services in recent years may have had on these measures.

Evidence from SSAs quality assurance reviews shows a decline over the last few years in the quality or accuracy of State disability decisions, particularly those decisions to deny benefits. Such a decline has accompanied significant increases in workload and production for the DDSs.

The increases in errors reported by SSA appear to support concerns raised by some DDS administrators over the last few years about the impact of resource reductions on their case development. These factors may also have contributed to an increase in the number of benefit awards made on appeal.

Beginning in 1987, we cautioned against placing budget constraints on the disability program. We reported to this subcommittee then that the increasing pressure of doing more cases with fewer examiners and physician staff could lead examiners to take shortcuts which could adversely affect the quality of decisions.

From 1986 to 1990, there has been a 10-percent increase in disability cases processed, with a 16-percent decrease in staff years at the DDSs. Pending caseloads for initial decisions at the DDSs are growing, resulting in longer processing times for decisions. Initial cases pending at the DDSs have increased 37 percent, from March 1990 to March 1991. The situation is not expected to get better.

SSAs budget justifications project that by the end of fiscal year 1992, 703,000 initial claims may be pending in the DDSs, an in-

crease of more than 80 percent from the 384,000 claims pending at the end of fiscal year 1990.

Many claimants denied at the initial level have to wait until they present their case before an ALJ to be allowed benefits. The success or allowance rate for these claimants that appeal to this level is about 63 percent. This high rate raises questions about the accuracy of the earlier decisions, and calls for explanations of why ALJs allow so many of the claimants who were denied earlier.

ALJs have historically had high allowance rates. While studies have found that many factors contribute to the high ALJ allowance rate, a significant factor and a difference between the ALJ decision process and that of the DDS is the face-to-face appearance of the claimant. At hearings, ALJs, often with the help of a medical advisor, ask claimants questions about their work history, current activities, and provide perceptions of impairments, and generally form an opinion about the claimant's credibility.

Another reason for the high ALJ allowance rate is that DDSs and ALJs tend to conclude differently about the work-related functions claimants are able to do on a sustained basis, despite their impairments. This residual functional capacity or RFC assessment is a key element in determining disability.

Our previous work found these assessments to be a major area of disagreement between the DDS adjudicators and the ALJs. In making RFC determinations, ALJs generally seek more information from treating physicians or consulting medical examiners on claimants' abilities to perform basic work activities than the DDS adjudicators. The DDS staff, without observing the claimants, tend to rely more on their own judgments of the claimants' functional capacities.

We support efforts to better involve treating or consulting physicians in the determinations of claimants' RFCs. Physicians who have observed and examined claimants should be in a better position to provide medical assessments of claimant's functional capacity, such as the capability to walk, lift, et cetera.

We also believe that conducting face-to-face interviews of selected categories of claimants at the initial or reconsideration stage could improve DDSs RFC determinations. As stated in our report on face-to-face interviews, experiments with such interviews at the reconsideration stage by two DDSs suggested that the interviews improved decisional quality of the DDS and resolved some cases that would have otherwise become appeals to the ALJs.

A larger-scale application of face-to-face interviews at the DDS level may have merit. A broad structural change to offer all or most claimants a face-to-face meeting with adjudicators at the initial decision level, however, may be costly. H.R. 1799 provides for all claimants to be offered an opportunity for a face-to-face interview at the initial decision level. We question whether face-to-face meetings are necessary for those cases where an allowance decision is likely based on a file review. Limiting such meetings, for example, to those cases where a denial decision is likely would appear to save substantial administrative costs.

This concludes my statement, Mr. Chairman, and I will be pleased to answer any questions you might have.

[The prepared statement follows:]

STATEMENT OF JOSEPH F. DELFICO, DIRECTOR OF INCOME SECURITY ISSUES HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss efforts to improve the initial decision making on social security disability claims, and to explore reasons why many claims are only allowed after hearings by administrative law judges (ALJs). Specifically, my remarks will address concerns we have about disability case processing accuracy and timeliness, and the impact budget constraints placed on the state disability determination services (DDSs) in recent years may have had on these measures. I will also discuss concerns we have about the DDSs' inability to meet all disability workload needs including continuing disability reviews (CDRs)[1].

Also, I will comment on two key provisions of H.R. 1799, the Disability Appeals Process Reform Act of 1991. These two provisions, providing for face-to-face interviews at the initial decision level and the elimination of reconsideration[2] as a level of appeal, are designed to improve decision making and to streamline the appeals process.

The Social Security Administration's (SSA's) quality assurance (QA) reviews show a decline over the last few years in the quality or accuracy of state disability decisions, particularly those decisions to deny benefits. Such a decline has accompanied significant increases in workload and production for the DDSs.

The increases in errors reported by SSA's QA program appear to support concerns raised by some DDS administrators over the last few years about the impact of resource reductions on their case development. These factors may also have contributed to an increase in the number of benefit awards made on appeal. ALJs are allowing[3] about 63 percent of the claims that are appealed to them. This has grown steadily from about 50 percent during 1985 and 1986.

INDICATIONS OF DETERIORATING QUALITY OF INITIAL DECISIONS

There has been a marked decline in quality beginning in 1987. Those claimants who are initially denied benefits appear to be affected the most. The QA error rate of DDS initial allowance decisions went from 2.4 percent for fiscal year 1986 to 3.1 percent for fiscal year 1989; then it improved slightly to 2.9 percent for fiscal year 1990. The error rate of DDS denial decisions increased more dramatically, from 4.3 to 7.0 percent during the same period. About two-thirds of the recorded errors were for documentation deficiencies.

Beginning in 1987, we cautioned against placing budget constraints on the disability program. We reported[4] to this subcommittee then that budget cuts had resulted in DDSs doing

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[1]CDRs are done to assess whether individuals on the disability rolls have medically improved enough to work. A provision in the Social Security Disability Amendments of 1980 requires SSA to review, at least every 3 years, beneficiaries whose conditions are not considered permanent.

[2]The reconsideration stage is the first level of appeal provided by the DDSs.

[3]Often the rate of allowances by ALJs is referred to as a "reversal" rate. SSA, however, prefers to call this an allowance rate because often the situation in a given disability claim has changed since the initial decision.

[4]Social Security: Effects of Budget Constraints on Disability Program (GAO/HRD-88-3, October, 1987)

less than the required number of CDRs, and that this was not cost effective. We also noted that while the 1984 disability amendments called for more extensive case development, the increasing pressures of doing more cases with fewer examiner and physician staff could lead examiners to take shortcuts, which could adversely affect the quality of decisions.

From 1986 to 1990, there has been a 10-percent increase in disability cases processed, with a 16-percent decrease in staff-years at the DDSs. Pending caseloads (for initial decisions) at the DDSs are growing, resulting in longer processing times for decisions. Initial cases pending at the DDSs have increased 37 percent from March 1990 to March 1991. The situation is not expected to get better. SSA's budget justifications project that by the end of fiscal year 1992, 703,000 initial claims (about 20 weeks of work) may be pending in the DDSs, an increase of more than 80 percent from the 384,900 claims pending at the end of fiscal year 1990.

Many claimants denied at the initial level have to wait until they present their case before an ALJ to be allowed benefits. As noted earlier, the success (or allowance) rate for those claimants that appeal to this level is about 63 percent. This high rate raises questions about the accuracy of the earlier decisions, and calls for explanations of why ALJs allow so many of the claimants who were denied earlier.

ALJ DECISIONS AIDED
BY FACE-TO-FACE CONTACT

ALJs have historically had high allowance rates. Concerns over the high rates have led to several studies[5] of the ALJ process. While many factors have been found to contribute to the high ALJ allowance rate, a significant factor and a difference between the ALJ decision process and that of the DDSs is the face-to-face appearance of the claimant. At hearings, ALJs ask claimants questions about their work history, current activities, and perception of impairments, and generally form an opinion about a claimant's credibility. An ALJ may also use a medical advisor to render an opinion on the severity of the claimant's impairment and its impact on the claimant's capacity for work-related activities. Medical advisors observe claimants at hearings and review medical evidence.

Another reason for the high ALJ allowance rate is that DDSs and ALJs tend to conclude differently about what work-related functions claimants are able to do on a sustained basis, despite their impairments. This "residual functional capacity" (or RFC)[6] is a key element in the determination of disability. Our previous work found these assessments to be the major area of disagreement between the DDS adjudicators and the ALJs. In a

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[5]One such study was done by SSA in 1981. The study (referred to as the Bellmon Study) of 3,600 decisions sought to determine, among other factors, the effect of face-to-face interviews of claimants at hearings. The study concluded that the in-person appearances of the claimants contributed significantly to the high allowance rates. Other identified factors were (1) distinct differences in the adjudicatory standards and procedures followed by ALJs and DDSs, and (2) the introduction of new evidence (often identifying that medical conditions had worsened) following the DDS decisions.

[6]See Appendix I for a definition of RFC, and a brief description of its applications.

report[7] we issued to this subcommittee 2 years ago, we found that disagreement over RFC was the principal cause for high allowance rates by ALJs for claimants aged 55 to 59 with back disorders, heart conditions, lung disease, diabetes, or anxiety. For example, of cases involving claimants with back disorders aged 55 to 59 who had been awarded benefits by ALJs, RFC was the basis for ALJ allowances in 86 percent.

DDS assessments of claimants' RFCs were often much higher than those of ALJs. For example, in reviewing the RFCs in a sample of 242 cases where ALJs had awarded benefits following DDS denials, we found that while DDSs had determined that 54 percent of the claimants could do medium or heavy work, the ALJs determined that less than 1 percent could do such work. Similarly, while ALJs determined that 71 percent of the claimants could do only sedentary work or less, the DDSs concluded that only 1 percent of them were so limited.

In making RFC determinations, ALJs generally seek more information from treating physicians or consulting medical examiners[8] on claimants' abilities to perform basic work activities than do the DDS adjudicators. The DDS staff, without observing the claimants, tend to rely more on their own judgments of the functional limitations of the claimants' impairments.

We support efforts to better involve treating or consulting physicians in the determinations of claimants' RFC. Physicians who have observed and examined claimants should be in a better position to provide medical assessments of claimants' functional limitations (such as the capabilities to walk, lift, etc.).

SELECTIVE FACE-TO-FACE INTERVIEWS APPEAR DESIRABLE

We also believe that conducting face-to-face interviews of selected categories of claimants at the initial or reconsideration stage could improve DDSs' RFC determinations. As stated in our report on selective face-to-face interviews, experiments with such interviews at the reconsideration stage by two DDSs suggest that the interviews improve decisional quality at DDSs and resolve some cases that would otherwise become appeals to ALJs.

A larger scale application of face-to-face interviews at the DDS level may have merit. We are awaiting, as I am sure this subcommittee is, for the final results of SSA's experiments with such interviews during its Personal Appearance Demonstration (PAD) project[9]. The HHS Office of Inspector General (OIG) issued an interim report on its initial evaluation on January 18, 1990. Early results indicate that claimants and disability examiners

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[7]Social Security: Selective Face-to-Face Interviews with Disability Claimants Could Reduce Appeals (GAO/HRD-89-22, April, 1989)

[8]Consulting medical examiners should not be confused with in-house DDS physicians. DDS physicians, with rare exceptions, do not examine or see claimants. They make their medical judgments based on evidence in case files. Consulting examiners are selected by DDSs to examine claimants and provide medical evidence when insufficient evidence is available from claimants' treating physicians.

[9]The Social Security Benefits Reform Act of 1984 required the conduct of demonstration projects in which claimants were offered the opportunity for a personal meeting with the decision maker prior to an unfavorable disability determination. The demonstrations were conducted in 10 states between March, 1986 and January, 1988.

thought the personal interviews improved the decision process and the claimants' understanding of the process. Apparently, however, the interviews did not discourage denied claimants from further appeals. The OIG reported that 68 percent of the claimants who were denied benefits after their interview said they planned to appeal the decision.

Offering all or most claimants a face-to-face meeting with adjudicators at the initial decision level may be quite costly. The OIG reported that DDS examiners spent up to 8 hours more per case under PAD than under the current process. In addition to increased costs, DDS management suggested to the OIG that full implementation would require major changes in the operation and orientation of the DDSs, and present problems with respect to staffing and arranging for the interviews.

H.R. 1799 provides for all claimants to be offered an opportunity for a face-to-face interview at the initial decision level. We question whether face-to-face meetings are necessary for those cases where an allowance decision is likely based on a file review. Limiting such meetings, for example, to those cases where a denial decision is likely, would appear to save substantial administrative costs. Another option is for DDSs to offer personal interviews to claimants when the DDS examiners (including physicians) know that their conclusions about the severity of the claimant's medical problems are in contradiction to those of treating sources. This would appear to offer a timely opportunity to better resolve a known conflict, and possibly save the claimant from having to appeal to an ALJ. The DDSs, perhaps, should also be given the flexibility to offer such in-person contact in any case where the staff believe it would significantly aid decision making.

RECENT EFFORTS BY SSA TO IMPROVE INITIAL DECISIONS

SSA recognizes the possible benefits of earlier face-to-face contact. This and other process changes are being examined by the Office of Disability at the request last year of the Commissioner. From the internal memorandums and discussion papers we have seen, it appears that the Commissioner is committed to improving the disability adjudication process, with particular emphasis on improving initial decisions.

We are not aware of any recent decisions to experiment with or implement specific changes to the current process. However, we can report that a group of DDS administrators and SSA staff was recently tasked with identifying ways to improve the process and that they have developed a number of options to pursue. These options include using state disability examiners or federal disability specialists rather than district office claims representatives to handle initial claims intake. Unlike current claims representatives, federal disability specialists would be specially trained in disability adjudication similar to DDS examiners. Other options include various means of providing face-to-face interviews at the initial decision level.

STREAMLINING APPEALS THROUGH ELIMINATION OF RECONSIDERATION

The current process takes too long for claimants who appeal state decisions, and we support efforts to shorten this time. H.R. 1799 provides for the elimination of the reconsideration stage of appeal. If this bill is enacted, and the necessary resources are provided, social security claimants would receive more timely decisions on appeal.

However, in our view, there are a number of unanswered questions about: (1) the resulting appeal rates of denied disability claimants, and the related impact on ALJ workloads; and (2) the

costs to SSA and related resource implications for the state DDSs.

The elimination of reconsideration will likely increase the workload for ALJs. We estimate that as many as 180,000 additional cases could be expected to go to ALJs each year, which would add between $100 and $200 million in new administrative costs. Some of the additional cost due to increased ALJ workloads could be offset by savings from eliminating the earlier case reviews at the reconsideration level, many of which are reviewed again by ALJs. However, estimating these savings is difficult.

BUDGET CONSTRAINTS
LIMITING CDR WORKLOADS

We testified before this subcommittee on October 6, 1987, regarding the effects of budget constraints on SSA's disability programs. We pointed out that because of reductions in DDS staffing, SSA limited the numbers of CDRs it expected DDSs to process.

Many CDRs are still not being done, and a backlog is growing. As a result, savings to the Disability Insurance Trust Fund are being lost because thousands of beneficiaries are being unjustifiably continued in payment status.

Generally, there are three types of disability workloads processed by DDSs--initial applications for benefits, requests for reconsideration reviews, and CDRs. Initial applications and reconsiderations are considered priority and "nondiscretionary." SSA considers CDRs "discretionary", although they are legally mandated to be done.

The DDSs were only able to process 195,000 CDRs in fiscal year 1990, of which about 59,000 were medical improvement expected[10] cases. Current DDS activity reports show only about 22,000 CDRs completed (6,000 were medical improvement expected cases) during the first 6 months of this fiscal year.

Recent SSA data suggest that there are over 350,000 medical improvement expected cases for which scheduled review dates are past due. Also, new cases "come due" with scheduled review dates at the rate of about 21,000 a month, or 250,000 a year. These workload estimates do not include other types of CDRs also legally mandated to be done.

These cases should be reviewed. Termination rates for medical improvement expected cases have been about 10 to 12 percent in recent years. Recent projections from SSA's Office of the Actuary show a return of about $4.00 for every $1.00 spent reviewing medical improvement expected CDR cases. Also, using SSA data, we estimate a loss to the Trust Fund of about $4 to $5

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[10]Medical improvement expected cases are those cases for which DDSs schedule a review date at the time of initial award, based on an expectation that the beneficiaries' impairment(s) may improve. The review is scheduled to see if, in fact, the beneficiary has medically improved sufficiently to be able to work. Reviews of these cases generally produce a higher rate of termination than other categories of CDRs.

million per year in unnecessary benefit payments for every 10,000 medical improvement expected cases not reviewed.[11]

This concludes my statement. I will be pleased to answer any questions you may have.

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[11]In 1987, we estimated losses to the Trust Fund to be about $8 to $9 million per year in unnecessary benefit payments for every 10,000 medical improvement expected cases that were not reviewed. We based this calculation on projections from SSA's Office of the Actuary, which assumed at that time a cessation (or termination) rate of 20 percent. The SSA projections also allowed for reversals of some cessation decisions following appeals. As noted above, DDSs have only achieved cessation rates of around 10 to 12 percent in recent years for these types of cases.

RESIDUAL FUNCTIONAL CAPACITY DETERMINATIONS

Social security regulations define "residual functional capacity" (RFC) as a medical assessment of what work activity a person can do despite his or her functional limitations. RFC assessments occur when adjudicators determine that claimants cannot be awarded benefits on medical considerations alone.[12] In such cases, and before considering vocational factors, adjudicators working with state agency physicians decide what capacity for work claimants have.

In assessing the RFC for individuals with physical limitations, an adjudicator[13] is to consider the claimant's ability to do physical activities, such as walking, standing, lifting, and carrying. For example, an RFC for medium work means that the person can do work that involves lifting no more than 50 pounds at a time with frequent lifting or carrying objects weighing up to 25 pounds. Similarly, an RFC for heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of 50 pounds.

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[12]SSA has a list of impairments that are considered severe enough, in and of themselves, to prevent most people from doing any gainful activity. If the severity of a claimant's impairment(s) corresponds to that of an impairment in the list or is similar enough to be judged "equivalent", benefits are granted without further evaluation.

[13]SSA regulations specifically require that RFC determinations be made by state agency physicians. However, they are frequently made by adjudicators, with final approval by physicians. The HHS Office of Inspector General reported in 1989 that 75 percent of the state agencies they surveyed said that their physicians never or seldom prepare RFCs themselves.

Chairman JACOBS. Thank you, Mr. Delfico.

Mr. Bunning.

Mr. BUNNING. Just a couple of questions. Mr. Enoff said that all of these are done separately by each State.

Mr. DELFICO. That is correct.

Mr. BUNNING. Does GAO have any recommendations for achieving a greater uniformity in the different States?

Mr. DELFICO. We do not have any recommendations. We have studied that issue for years, and I think it is a question that will remain open for years after this. The disparity among States is great. If you are referring to national standards, you have got them. The States are using the same standards. It boils down to the way the DDSs view the claimant and, to some degree, the philosophies of the different States on how they view disability. It is something we cannot get a handle on, because it is tough to assess empirically.

Mr. BUNNING. You do not have any suggestions, then, on how we can make it more uniform?

Mr. DELFICO. We can improve processes, but I think you are dealing with marginal effects when you do that. I think it is the philosophical differences among States that will have a large impact on the decisions.

Mr. BUNNING. You mentioned also that if we implemented H.R. 1799, it would be more costly. How much more costly?

Mr. DELFICO. We have not made an estimate of that. I heard the CBO number earlier and I have not seen the details of that particular estimate, but it sounds awfully large.

The cost-oriented part of our discussion deals with eliminating the reconsideration process. As applied to our understanding of the process, if you eliminate the reconsideration process, you will then have all appeals going directly to the ALJs. It is a more costly process. The ALJs' costs are higher and, therefore, it costs more to process an appeal.

Mr. BUNNING. How many more ALJs do you think they need to implement H.R. 1799?

Mr. TICE. We estimated that the increased workload could be around 180,000 to 200,000 cases, and how that factors down to the number of administrative law judges, we have not looked at that.

Mr. BUNNING. You have not?

Mr. TICE. Pardon me?

Mr. BUNNING. You have not looked at that?

Mr. TICE. No, sir.

Mr. BUNNING. And do you think that if, in fact, we could——

Mr. TICE. We could come up with some ballpark estimates based on the average production per administrative law judge and what that might entail.

Mr. BUNNING. If we did test this, do you think it could be implemented by 1992?

Mr. DELFICO. Fiscal 1992?

Mr. BUNNING. Fiscal 1992.

Mr. DELFICO. I think it is highly unlikely.

Mr. BUNNING. Thank you.

Mr. DELFICO. One other point, Mr. Bunning. There is a cost savings that I did not mention in my discussion. There is a savings in

that the DDSs are eliminating the reconsideration stage, but we have not estimated that cost savings.

Mr. BUNNING. Thank you.

Chairman JACOBS. Mr. Crane.

Mr. CRANE. I have no questions.

Chairman JACOBS. Mr. Delfico, thanks for your contribution. As usual, it is gratefully received.

Mr. DELFICO. Thank you.

Chairman JACOBS. Our first panel for the day, the Honorable Arthur S. Flemming, chairman, Save Our Security Coalition; Administrative Conference of the United States, Mr. Marshall Breger; the American Bar Association, Mr. John Pickering; and the National Senior Citizens Law Center, Eileen Sweeney.

As you can see, time has not been our friend this morning, so we do ask the witnesses, if you can beat 5 minutes, you curry enormous favor with the committee.

Dr. Flemming.

STATEMENT OF HON. ARTHUR S. FLEMMING, CHAIR, SAVE OUR SECURITY COALITION, AND FORMER SECRETARY OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. FLEMMING. Mr. Chairman, I appreciate this opportunity to testify on behalf of the Save Our Security Coalition.

As you know, I have been chairing a panel for the Commission on Social Security, taking a look at SSI. In connection with that operation, we have held public hearings in New York, Chicago, Los Angeles, Montgomery, Atlanta, and just yesterday in Wilkes Barre, Pa.

About half of the witnesses that appeared before us have testified relative to delays in the handling of disability cases. Consequently, I welcome the decision on the part of this committee to give consideration to the bill introduced by the chairman.

I believe that the statement made, Mr. Chairman, by you in introducing the Disability Appeals Process Reform Act of 1991 is an accurate analysis of the situation now confronting us.

The provisions of H.R. 1799 are very much needed. A face-to-face interview early in the process with the decisionmaker will help to assure that medical problems, particularly mental impairments and limitations in daily living activities are not overlooked. SOS agrees that reconsideration should be eliminated. This step adds months to decision and very few cases are reversed at this step.

A section in H.R. 1799 setting forth the evidence needed in the file will assure that, in most instances, disability determination services are looking at the same kinds of evidence that administrative law judges consider.

We do recommend three changes in this particular part of the law. I will not go into them at this time.

I would like to suggest that the committee, in its oversight capacity, examine the question of whether the administrative law judges are required to adhere to all of the policy instruction to which DDSs must adhere.

We urge, Mr. Chairman, that if you decide to report out H.R. 1799, that you include in it an authorization for the funds required to implement the provisions of the law.

I have noted with interest the estimate of the Congressional Budget Office.

We also urge that this committee's report point out the fact that a major reason for the extended delays in handling disability cases and for the decline in the quality of case development is the serious understaffing of the program. This situation, in my judgment, in our judgment, Mr. Chairman, is not addressed in the President's budget for 1992.

Having served in the executive branch, I recognize that representatives of the executive branch are required by law to support the President's budget, but I submit to you that the amount included in the President's budget for this particular process is not adequate.

Quite the contrary, the budget submitted states that the pending file of disability cases at the end of fiscal 1992 will be 708,000, an increase of 80 percent over the pending file at the end of fiscal year 1990. From our point of view, that just does not make sense, and it seems to me that this committee should take a look at that and consider making recommendations to the Appropriations Committee on this particular point.

We believe that the changes proposed in the disability adjudication process, when underpinned with adequate staffing, will assure that those who are disabled will receive their benefits as soon as possible, not after months or years of needless waiting. This is a far better way, in our judgment, of dealing with the problem than by establishing a Social Security Court.

We believe it is important for Social Security and SSI beneficiaries to have access to Federal District Court. We believe that these generalist courts, with their fresh perspectives, have done an outstanding job of protecting the applicants and beneficiaries that we represent. Let us strengthen what we have. H.R. 1799 and more appropriations for staff will achieve our goals.

Thank you, Mr. Chairman.

[The prepared statement of follows:]

STATEMENT OF ARTHUR S. FLEMMING, CHAIR, SAVE OUR SECURITY COALITION, FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

I. Introduction

A. I appreciate this opportunity to testify on behalf of the Save Our Security Coalition. SOS is a coalition of organizations dedicated to providing public support for our Social Security system.

B. This past year, it has been my privilege to serve as the chair of the SSI Modernization Panel. This panel was appointed by Commissioner King to make recommendations about changes needed in the SSI program. In my capacity as chair of that panel, I have visited all ten SSA regional offices, district offices, and also six state disability determination services. I have also chaired public hearings in five locations across the country.

C. At these hearings, witnesses have testified repeatedly regarding (1) long delays in the disability determination and appeals process, (2) the fact that many who are denied at the initial and reconsideration stages ultimately prevail, and (3) the human suffering which results from the long delays caused by lengthy and often unnecessary appeals. In the disability area, witnesses have generally not limited their testimony to SSI disability issues; the parallel disability problems under Social Security have also been addressed.

II. Body

A. I believe that the statement made by Congressman Jacob in introducing the Disability Appeals Process Reform Act of 1991 is an accurate analysis of this situation now confronting us.

B. The provisions in H.R. 1799 are very much needed.

1. A face-to-face interview early in the process with the decisionmaker will help to assure that medical problems, particularly mental impairments, and limitations in daily living activities are not overlooked.

2. SOS agrees that reconsideration should be eliminated. This step adds months to decisions and very few cases are reversed at this step.

3. The section in H.R. 1799, setting forth the evidence needed in the file will assure that, in most instances, Disability Determination Services are looking at the same kinds of evidence that Administrative Law Judges consider.

4. There are three changes we recommend.

a. First, there should be a requirement that the DDSs affirmatively seek evidence regarding limitations on daily living activities from claimants, their relatives, and friends. All too often, claimants' impairments or limited education preclude them from understanding, much less actually providing, the types of evidence needed.

b. Second, it is very important that SSA and the DDSs seek evidence regarding the extent and duration of pain and the claimant's residual functional capacity from not only the physicians paid by SSA and the DDSs but also from the treating physicians, hospitals and clinics of the claimant.

c. Third, under SSA's contractual arrangement with the DDSs, the states should be barred from including DDS under state hiring freezes and other limitations on spending. As DDSs are fully federally funded, it makes no sense to permit states to limit DDS staffs, which has a direct impact on SSA's ability to process this critical workload, when SSA pays 100% of the cost of the state's processing.

d. Also I would like to suggest that the committee, in its oversight capacity, examine the question of whether the Administrative Law Judges are required to adhere to all of the policy instructions to which the DDSs must adhere.

C. We urge that H.R. 1799 authorize the additional funds required to implement the provisions of this law.

D. We also urge that this Committee's report point up the fact that a major reason for extended delays in handling disability cases and for the decline in the quality of case development is the serious understaffing of the program.

1. This situation is not addressed in the President's Budget for 1992.

2. Quite the contrary, The Budget as submitted states that the pending file of disability cases at the end of fiscal 1992 will be 708,000--an increase of 80% over the pending file at the end of fiscal year 1990.

IV. Conclusion

A. We believe that the changes proposed in the disability adjudication process when underpinned with adequate staffing will assure that those who are disabled will receive their benefits as soon as possible not after months or years of needless waiting.

B. This is a far better way of dealing with the problem than by establishing a Social Security Court.

1. We believe it is important for Social Security and SSI beneficiaries to have access to federal district courts.

2. We believe that these generalist courts--with their fresh perspectives have done an outstanding job of protecting the applicants and beneficiaries they represent.

3. Let's strengthen what we have.

4. H.R. 1799 and more appropriations for staff will achieve our goals.

Chairman JACOBS. Thank you, Dr. Flemming.
Mr. Breger.

STATEMENT OF MARSHALL J. BREGER, CHAIRMAN, ADMINISTRATIVE CONFERENCE OF THE UNITED STATES

Mr. BREGER. Thank you, Mr. Chairman.

I have a written statement and accompanying material that I would ask be placed in the record.

Chairman JACOBS. Without objection, it will be.

Mr. BREGER. As you know, the Administrative Conference is an independent Government agency charged with making recommendations to promote fairness and efficiency in the administrative process. We have engaged in a number of studies of the Social Security process, I might add, in many cases with the encouragement and at the request of the Social Security Administration, and we have a number of recommendations on the process, in particular, our recommendation 90-4, and 89-10, which will form the basis of my comments today.

We support the thrust of H.R. 1799, which we view as an effort to perfect the quality of the front end of the adjudicative process in the Social Security disability area.

As you know, there are four bites, so to speak, at the apple on the administrative side of Social Security disability, and three further stages of judicial review. There is the initial disability determination, the reconsideration stage, the ALJ hearing, and the Appeals Council review.

Most of the discussion in the past has been on improving the back end of the process, the appeal side. We think it is time to put more effort into getting a quality decision at the front end. Ultimately that will save time at the back end, and, indeed, we think will create greater efficiency in the entire process.

In that regard, we have two comments: We support the notion of a face-to-face hearing at an early stage. I make a footnote that we would call it an informal hearing, rather than an evidentiary hearing, because we do not think there should be a full formal hearing that the phrase "evidentiary hearing" suggests; that is much more formality than should be appropriate at this initial determination phase. We think an eyeball test, in which the adjudicators actually can see the applicant, can often solve a lot of problems right there. Further, it is a lot easier to focus the applicant on the medical record material that is needed, if they are present and having a face-to-face discussion.

Second, we think it is important to get a fuller record, a medical record, in particular, before making the initial adjudicative decision. This hearing process differs from most adjudicative processes, because the record is open through all four stages, and you can add material to the record. That means there is not much incentive to get a full record at the beginning. You could say, well, I will decide on what I have here, and if someone wants to add something, they will add it down the line. This means that decisions are made on incomplete information and, very often, if you had the medical record before you, the decision would be clear, would be obvious.

We think the proposal to require that the claimant be notified as to what is lacking in the medical record is important, and we think the effort to hold the decision up until you get a full record is also important. Indeed, we recommend, although this is not in the bill, that at the ALJ stage, subpoenas be available, if necessary, to secure the necessary medical information.

To conclude, we think that this is an important effort to begin to rationalize and add both fairness and efficiency to the entire Social Security disability process.

I would be happy to answer any questions that you might have.

Thank you.

[The prepared statement follows:]

STATEMENT OF MARSHALL J. BREGER, CHAIRMAN ADMINISTRATIVE CONFERENCE OF THE UNITED STATES

I am pleased to have been invited to testify today on H.R. 1799, the Disability Appeals Process Reform Act of 1991, which would provide for a face-to-face hearing for social security disability claimants prior to an initial determination on whether benefits should be granted, would eliminate the "reconsideration" stage, and would require certain additional medical and other information to be included in the record of a determination. The Administrative Conference of the United States has a long-standing interest in the procedural aspects of the Social Security disability programs. We have undertaken at least one (and in some cases more than one) study of each of the administrative levels of the determination and appeals process, and we have adopted several relevant recommendations over the years. We appreciate the opportunity to testify at this hearing, and we hope that our testimony will be helpful. We support the bill's objectives.

The Role of the Conference

Let me start by telling you something about the Conference. Created by statute in 1964, the Administrative Conference of the United States is an independent federal advisory agency charged with responsibility for studying the efficiency, adequacy and fairness of federal administrative procedures and recommending improvements. It includes among its members both representatives of all major government departments and agencies with regulatory or policymaking responsibilities and members of the public -- generally practicing lawyers, legal scholars, or others with special expertise in administrative procedures -- all of whom serve on a volunteer basis. Meeting twice a year in plenary session and more frequently in smaller committees, Conference members review studies prepared by outside experts on a wide variety of issues and problems related to agency practice and procedure. Based on these studies, the Conference develops recommendations, which may be addressed to administrative agencies, the President, Congress, or the Judicial Conference of the United States, as appropriate. I am gratified that, in the 101st Congress alone, our work has been considered to have had sufficient merit that Congress specifically incorporated our recommendations, or took our work into account, when enacting six separate pieces of legislation.

Conference Study of the Disability Process

The Conference has studied and issued recommendations relating to the Social Security disability program several times over the last 15 years. These include studies on each of the stages of the determination and appeal process, as well as a supplementary overview recommendation and a recommendation on the use of medical decisionmakers. These recommendations have addressed a number of issues raised by the legislation before the Committee today and, to the extent that they have, I speak this morning on the Conference's behalf. I do not speak for the Administration.

The Conference has carefully studied each of the three major steps in the social security hearings and appeal process -- the state level disability determination process, the administrative law judge hearing stage, and the operation of the Appeals Council.[1] Some (but not all) of these studies were done at the request of the Social Security Administration. Copies of the relevant recommendations are attached to my statement and we hope that they will be made part of the record. All of our recommendations are based on consultant reports that discuss the issues in detail. We have provided committee staff with copies of the reports underlying the recommendations discussed today. I will discuss these studies and the recommendations that derived from them as they relate to the bill before you now.[2]

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[1]See Recommendation 78-2, "Procedures for Determining Social Security Disability Claims," 1 CFR § 305.78-2; Recommendation 87-6, "State-Level Determinations in Social Security Disability Cases," 1 CFR § 305.87-6; Recommendation 87-7, "A New Role for the Social Security Appeals Council," 1 CFR § 305.87-7; Recommendation 89-10, "Improved Use of Medical Personnel in Social Security Disability Determinations," 1 CFR § 305.89-10; Recommendation 90-4, "Social Security Disability Program Appeals: Supplementary Recommendation," 1 CFR § 305.90-4.

[2]In addition, the Conference is currently studying the SSA process for designating "representative payees," a subject not addressed by H.R. 1799.

The Conference's recommendations contain a large number of detailed suggestions of ways the Social Security Administration can improve the decisionmaking process in the disability programs. Many of these suggestions probably do not require Congressional action. And, in fact, SSA has already implemented many of our proposals.

The Conference's recommendations have as their common theme the goal of making social security disability decisions as accurate as they can be as early in the process as possible, in order both to provide deserving beneficiaries with the benefits to which they are entitled, and to reduce the amount of resources necessary for appeal procedures. Obviously, improvements made at the early stages of the process, where the caseload intake is the largest, have the greatest benefit on the overall process. Thus, focusing on the first level of determination, as this legislation does, will have a beneficial effect on the entire disability process. Because this legislation focuses only on the initial stage, our comments will also be focused there. Our recommendations, however, also address the other administrative stages of the process.

The Disability Adjudication Process

The initial determination of disability is made by federally-funded state Disability Determination Services (DDS). A dissatisfied claimant may seek a reconsideration by a different individual in the DDS. This reconsideration decision is appealable to an administrative law judge (ALJ) in the Social Security Administration's Office of Hearings and Appeals, who holds a de novo hearing on issues on appeal. The ALJ's decision can be appealed to the Appeals Council, which reviews the case (as the delegate of the Secretary) and may in some instances permit supplementation of the record. Judicial review of the Appeals Council decision is available in the United States District Court.

Changes Proposed by H.R. 1799

The bill would make some significant changes in the structure of the disability determination process. It would provide for an "evidentiary hearing" before an initial determination is made by the state disability determination service. It would eliminate the "reconsideration" stage that is currently provided by the DDS before an applicant is permitted to appeal to an ALJ. It would also specify certain medical and other information that must be included in the record for the initial determination.

Conference Recommendations on the Adjudication Process

Let me address the various provisions of H.R. 1799 in light of the Conference's recommendations. The subjects of most of the provisions of the bill were addressed in Recommendation 89-10, "Improved Use of Medical Personnel in Social Security Disability Determinations." Our overall recommendation proposed a number of changes designed to enhance the medical fact-finding process used in the initial determination stage. Our proposal was intended to ensure that the necessary medical evidence is in the record before decisions are made and that qualified personnel are available to evaluate it. It also recommends that an opportunity be provided at this initial level for a face-to-face interview with the claimant. In conjunction with these recommendations, the Conference was prepared to eliminate the reconsideration stage. The expectation is that the need for such reconsideration is substantially reduced if the claimant has a chance to find out what information is needed before the initial decision is made, and is given an opportunity to meet with the decisionmakers, who then can ask questions about matters that are not clear on the written record.[3] It is important that any elimination of the reconsideration stage be coupled with efforts to ensure that the initial decisionmaking process is as accurate as possible.

The Conference recommendation suggests that the opportunity for face-to-face interaction between the claimant and the agency be in the form of an informal interview. The idea behind this recommendation is that it would permit the decisionmaker to acquire information from the claimant, and the claimant to put forth such information as he or she felt was relevant, without overly formalizing the

[3]The Conference also studied the DDS process in a 1987 study, which led to Recommendation 87-6, "State-Level Determinations in Social Security Disability Cases." This project evaluated SSA demonstration projects then underway testing the effects of face-to-face meetings. Because the projects were at an early stage at the time of the recommendation, the conclusions were preliminary. The underlying report, however, contains a discussion of many important issues.

process. The proposed legislation would also provide for a face-to-face meeting between the claimant and the agency, but it appears to cast it in much more formal terms. An "evidentiary hearing" seems to suggest that this interaction would be similar in form to the ALJ hearing that occurs later in the process. Such a procedure would be time-consuming, more structured and thus potentially intimidating to the applicant, unnecessary, and potentially redundant. It would also raise the specter of later elimination of the ALJ hearing, which, as an independent level of review, seems important to ensuring correct decisionmaking.

As noted, the Conference supports the idea of offering a claimant the opportunity to meet with an SSA representative (or a DDS representative) during the initial determination stage. Much useful information can be garnered in such an interview. The agency decisionmaker can observe first-hand the nature of some disabilities. Moreover, the claimant can be quickly and easily informed of additional information that may be needed, so that the record can be as complete as possible, as early in the process as possible.

On the other hand, if the "evidentiary hearing" is a formal hearing, some of these benefits may be overshadowed. The term "evidentiary hearing" does not clearly delineate the nature of the process. Although the simple term "hearing" has on occasion be interpreted by both agencies and courts to permit less than courtroom-like processes, the inclusion of the added word "evidentiary" would likely be interpreted to require some type of formal proceeding, in the nature of a hearing before an ALJ. If so, such a procedure would likely engender a perceived need to "prepare" for such a hearing, thus causing a substantial delay at this early stage in the process. It might encourage claimants to seek legal advice at a stage when it may be unnecessary in many cases. Moreover, if this "evidentiary hearing" is similar in nature to that of the ALJ hearing that occurs following the initial decision, this will build a redundancy into the system that it can ill afford, given the numbers of claimants involved. Such a redundancy may ultimately bring future calls to abolish or circumscribe the ALJ stage, which would eliminate the opportunity for an independent review of the record.

Thus, I would urge that the term "evidentiary hearing" in the bill be replaced by "personal interview" or "face-to-face meeting" or similar language that makes clear the informal nature of the claimant-agency conference.

With respect to the bill's requirements that additional medical and other information be included in the record of the determination, the Conference generally supports the provision. The Conference has recommended that the quality of the medical evidence in the record be improved. Among our suggestions are that the claimant be notified of any deficiencies in the medical evidence, that care be taken that the medical record is complete before the initial decision is made, and that guidelines be developed for establishing priorities as to the use of treating, examining and non-examining physicians.[4] The Conference recommends that all contacts with medical sources be documented in the record, and copies provided to the claimant.[5] The Conference has also recommended that subpoenas be used (at the ALJ level) when necessary to acquire medical records.[6]

Because there is such an important medical component to disability determinations, we believe that the quality of medical decisionmaking in this context is crucial. For that reason, the Conference's recommendation also addressed the need to enhance the role of the medical decisionmaker and provide the requisite trained staff.[7] We recommended that medical staff be used in developing the medical evidence, evaluating it, and resolving conflicts in connection with it.

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[4]Recommendation 89-10, ¶¶ 1, 4, 5(a).

[5]Id., ¶ 5(e).

[6]Recommendation 90-4, ¶3.

[7]Recommendation 89-10.

The specific types of information the proposed legislation would require to be in the record would seem to be consistent with the Conference's view that the record should be as complete as possible as early in the process as possible.

Finally, the Conference supports the elimination of the reconsideration step, if -- but only if -- the other steps discussed above are implemented. Those steps should serve to complete the record and improve the quality of decisionmaking at the early stages of the process such that reconsideration should not be necessary.

With respect to the specific questions we have been asked to address, I have the following comments.

Why are SSA disability determinations so frequently reversed on appeal? Why is the reversal rate rising?

It would appear that a major contributing factor to the high reversal rate in disability determinations is that additional relevant information which suggests that benefits should be granted is entered into the record as the process proceeds. In other words, the initial decisionmaker and the ALJ or Appeals Council are really working from different information. The record improves as the process moves along. It is to avoid just this type of situation that the Administrative Conference has consistently recommended that efforts be made to improve the quality of the record at the front end of the claims process. By the way, I am informed that in recent years, the reversal rate of SSA decisions at the district court level has fallen significantly below the historically high levels that occurred when SSA was following its controversial policy of "continuing disability reviews," which resulted in numerous people losing their benefits and a concomitantly high caseload across the system.

Can SSA decisionmaking be improved by expanding the information on which decisions are based? If so, what additional information should be gathered? Specifically, would a face-to-face interview before an initial decision improve the quality of decisions?

As noted above, the Conference believes that expanding the amount of available information on which decisions are based would improve decisionmaking. Improved medical information is particularly important. As I noted earlier, a relatively informal face-to-face meeting -- what your question describes as an "interview" -- could improve the quality of decisions by affording agency personnel the opportunity to observe and talk with claimants in person early in the process, and communicate with them directly to ensure that relevant information has been received. As I discussed above, we believe that an informal interview would be more productive at this stage of the process than a more formal proceeding.

What can be done to improve the timeliness of SSA decisions? Can the process be shortened or streamlined while maintaining the rights of claimants? If so, how?

The recommendation of eliminating the reconsideration stage, in conjunction with offering face-to-face meetings and improving the decisionmaking record at early stages, should have the effect of improving the timeliness of accurate decisions. The earlier in the process correct decisions are made, the less delay occurs for the claimants involved, the less wasted efforts are made by agency personnel, and the more efficient the process is overall.

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The Conference has also recommended that the Appeals Council review fewer cases, using its resources instead to provide improved guidance to lower level adjudicators. Such cases as it would still hear should ordinarily be resolved within 90 days.[5]

Some critics of the current disability determination process have pointed to the DDS's insularity as a cause of decision making errors. Is this a widespread problem? If so, would the establishment of DDS advisory groups consisting of medical and legal experts, government representatives, and advocates for the disabled improve the accuracy of decisions?

The Conference agrees that the DDS should have more access to medical expertise. To that end, the Conference has recommended that medical members of disability determining teams be given primary responsibility for developing the medical evidence, for evaluating the adequacy of physician reports and seeking any additional information that may be needed, and making the decision on medical issues.

Conclusion

The more time, effort, energy and thought that goes into a review of the disability process, the better that process will become. Improving the disability determination process at the front end, and improving the quality of decisionmaking at early stages, is the best way to improve the fairness and efficiency of the system. We believe that the basic ideas put forward in H.R. 1799 could improve the determination process for disability claims.

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[5]Recommendation 87-7.

§ 305.87-7 A New Role for the Social Security Appeals Council.

The Social Security disability system is described generally in Recommendation 87-6 which focuses on the initial determination process at the state-level Disability Determination Service (DDS) offices. This Recommendation addresses the later stages of review by the Social Security Administration (SSA).[1]

The first stage of review by federal decisionmakers is the third step in the process for disability claimants. Claimants disappointed after state-level initial and reconsideration determinations may then demand a hearing before an administrative law judge (ALJ) employed by the Social Security Administration. About 65% of such claimants do so. This is the first time in the process (except in certain demonstration projects or cases involving the termination of benefits) that a claimant has a face-to-face encounter with the decisionmaker. The hearings are de novo, and generally follow Administrative Procedure Act guidelines. Approximately 50% of appeals taken to an ALJ hearing result in the award of benefits.

The fourth, and final, level of administrative review is to the Social Security Appeals Council. This twenty member body, created by regulation, and chaired by the Associate Commissioner for Hearings and Appeals, disposes of a staggering 50,000 cases annually. (About 40% of claimants who lose at the ALJ stage appeal.) In addition to appeals from ALJ decisions, the Appeals Council reviews, on its "own motion," selected cases where there has been a grant of benefits. The Appeals Council relies on analysts in its companion unit, the Office of Appeals Operations (OAO), to screen cases and make recommendations concerning disposition of the cases. Council members hold the same salary grade level as SSA ALJs. They perform purely a paper review on cases that are forwarded to them by OAO and assigned to them individually based on the geographical origin of the case. The Appeals Council acts on each appeal, although in most cases the request for review is summarily denied or dismissed. Because of the demands on each member (up to 500 cases per member per month), a typical case is likely to receive less than 15 minutes of paper review by the member. The Council almost never sits in panels or conducts oral arguments. In recent years, approximately 5% of the cases reviewed result in reversals (i.e., awards of benefits), and another 7 to 15% are remanded to the ALJ.

After exhaustion of state and federal administrative remedies, a claimant may seek judicial review in the federal district court. In the years 1981 to 1986 the number of new SSA disability cases filed in the courts ranged from 9,000 to 26,000 per year.

In past years, the Appeals Council has to some extent played a policy-relevant role. Yet, as its caseload increased, it was by necessity limited to a narrow case correction function. Accordingly, its members had little time to devote to policy matters. Recently, the Appeals Council has come under attack from many fronts, including Congress, claimants and their representatives, and academicians, who have questioned both the Appeals Council's usefulness as an additional step in the adjudicative chain and the resulting delays caused to claimants who wish to proceed to court.

Critics have complained that the rate of reversals is so low that it fails to compensate for the additional delay caused to claimants who wish to seek judicial review. The Conference's study noted that because its members are so driven by the "tyranny of the caseload," it has failed to take advantage of its unique position as the final administrative review body—one that sees a diverse number of disability cases, and accordingly, can detect emerging problems, and identify new issues to be resolved and policies to be developed. Thus, any capabilities it should have in promoting consistency of lower-level decisionmaking, and policy integrity throughout the system, are thwart-

[1] The Conference has previously addressed elements of the Social Security appeals process (focusing primarily on the ALJ hearing stage) in Recommendation 78-2, Procedures for Determining Social Security Disability Claims, 1 CFR 305.78-2.

ed, and it is left with little more than a case-handling role.

The Social Security Administration requested the Administrative Conference to study and analyze the operation of the Appeals Council.

Serious consideration was given to recommending outright abolition of the Appeals Council. This view was premised on the Appeals Council's present inability to do little more than add one more layer to the already-lengthy review bureaucracy. (This criticism was not intended as a denigration of Appeals Council members, whom the study found to be competent, dedicated, and cooperative.) Before recommending such a drastic, and irreversible step, however, the Conference felt that an attempt should be made to use the unique perspective and expertise of the Appeals Council to help correct the existing problem. The Conference believes that fundamental changes are needed to reduce the Council's caseload to a more manageable volume, so that individual cases can be given more attention and the Council can be a significant contributor to agency policymaking. Accordingly, to implement a system-reform function for the Appeals Council, the Conference makes the following Recommendations for modification of its structure, purpose and operations.

While the recommendation anticipates a reduced volume of cases for the Appeals Council, the Conference believes that improved fact-finding will result from the changes in initial determinations (*see* Recommendation 87-6), and that this will compensate for diminished factual review at the Appeals Council stage.

RECOMMENDATION

1. The Social Security Administration (SSA) should, as soon as feasible, restructure the Appeals Council in a fashion that redirects the institution's goals and operation from an exclusive focus on processing the stream of individual cases and toward an emphasis on improved organizational effectiveness. To that end, the Appeals Council should be provided the authority to reduce significantly its caseload and also be given, as its principal mandate, the responsibility to recommend and, where appropriate, develop and implement adjudicatory principles and decisional standards for the disability determination process. In particular, SSA should adopt the following structural reforms to improve the Appeals Council's ability to perform its new function.

a. *Focus on System Improvements.* SSA should make clear that the primary function of the Appeals Council is to focus on adjudicatory principles and decisional standards concerning disability law and procedures and transmit advice thereon to SSA policymakers and guidance to lower-level decisionmakers. Thus the Appeals Council should advise and assist SSA policymakers and decisionmakers by:

(1) Conducting independent studies of the agency's cases and procedures, and providing appropriate advice and recommendations to SSA policymakers; and

(2) Providing appropriate guidance to agency adjudicators (primarily ALJs, but conceivably DDS hearing officers in some cases) by: (a) Issuing, after coordination with other SSA policymakers, interpretive "minutes" on questions of adjudicatory principles and procedures, and (b) articulating the proper handling of specific issues in case review opinions to be given precedential significance. The minutes and opinions should be consistent with the Commissioner's Social Security Rulings. Such guidance papers should be distributed throughout the system, made publicly available, and indexed.

b. *Control of its Caseload.* On order to fulfill its responsibility to develop, and to encourage utilization of, sound decisional principles and practices throughout SSA, the Appeals Council must be empowered to exercise its review sparingly, so that it may concentrate its attention on types of cases identified in advance by the Appeals Council. These types of cases might include a small sample of random cases or categories identified by the Secretary of Health and Human Services from time to time. To that end, the Secretary should direct the Appeals Council to design a new review process, subject to the Secretary's approval, that would continue to be part of the available administrative remedy for a claimant dissatisfied with an administrative law judge's (ALJ's) initial decision, but that would enable the Appeals Council to deny a petition for review if the issues it sought to raise are deemed inappropriate for the Appeals Council's attention. If a petition for review is denied, the ALJ's decision

should be deemed to be final agency action.

c. *Improved Review of Individual Cases.* The Appeals Council, given a reduced caseload, should upgrade its handling of individual cases. In particular the Council should:

(1) Work more collaboratively, including as appropriate, considering cases en banc or in panels;

(2) Encourage claimant's representatives to submit briefs (including *amicus* briefs) on selected issues and evaluate the benefits of encouraging oral arguments in appropriate cases (utilizing existing authority to reimburse participants as necessary);

(3) Write more elaborate opinions, providing better reasoning and legal analysis and relying less on boilerplate and verbatim recitation of records;

(4) Avoid substitution of judgment on ALJ factual determinations; [2]

(5) Significantly reduce the time needed to initiate or deny review of cases and issue a final decision in most cases within 90 days of accepting review, unless an extension or delay request by a claimant is granted for good cause; and

(6) Specify that once the period for accepting review has passed, ALJ decisions should be deemed to be final agency action, and should be subject to reopening by the Appeals Council only in accordance with existing standards.

d. *Enhancement of Status of Appeals Council.* SSA should improve the status of the Appeals Council and insure high caliber appointment by:

(1) Reducing the size of the Council so that the Council can meet and act more collegially;

(2) Upgrading the salary level of members so that it is one level above SSA ALJs;

(3) Providing the members, by regulation, with the same civil service protections as accorded to career service personnel and by providing ALJs who agree to serve on the Council with assurances that they will receive reappointment to their former position upon completion of service; and

(4) Establishing merit selection criteria for appointment to the Appeals Council, giving preference to prior experience as an ALJ.

e. *Enhancement of Support Systems.* SSA should improve the support system provided to its Appeals Council by reorganizing the Office of Appeals Operations, providing law clerks to assist members, and updating production and communication systems.

f. *Enhance the Appeals Council's Visibility.* The Appeals Council should enhance its visibility both inside and outside the agency by reinstating the "visiting ALJ" program,[3] instituting exchange programs with other SSA components, seeking publication of precedent by a recognized reporter service, and encouraging other outreach and bar-related activities.

2. If the reconstituted Appeals Council does not result in improved policy development or case-handling performance within a certain number of years (to be determined by Congress and SSA), serious consideration should be given to abolishing it.

[52 FR 49143, Dec. 30, 1987]

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[1] In conjunction with this reliance on the record below, the Appeals Council should not permit new evidence to be introduced without good cause, although motions to remand to the hearing stage should be permitted. See Recommendation 78-2, ¶ (c)(1); 1 CFR 305.78-2(c)(1).

§ 305.89-10 Improved Use of Medical Personnel in Social Security Disability Determinations (Recommendation 88-10).

The Social Security Administration annually processes more than 1.5 million requests for Disability Insurance Benefits and Supplemental Security Income requiring a determination whether the claimant is disabled. The Administrative Conference has addressed various aspects of the Social Security Administration's administrative procedures in earlier recommendations.[1] This recommendation focuses more specifically on the appropriate use of medical personnel in making disability determinations.

The Social Security Administration (SSA) uses medical personnel currently in two ways. First, initial and reconsideration determinations are made for SSA by federally funded state agencies that use teams composed of one lay disability examiner and one medical doctor or psychologist.[2] Second, medical sources are used to provide evidence of disability in individual cases and to explain or elaborate upon medical evidence obtained from other sources. Medical sources provide evidence relating to individual claims to state agencies at the initial decision and reconsideration levels, to administrative law judges at the hearing level, and to the Appeals Council. Requests can be made to the claimant's treating physician or to an independent physician who is asked to examine the claimant and report on his or her findings. Doctors are asked by some administrative law judges to explain or elaborate upon existing medical evidence; other administrative law judges and most state agency personnel do not use independent medical doctors for these purposes. Medical personnel are involved in the disability determination process for other federal disability programs as well. Although the extent to which they are used varies from program to program, programs typically concentrate the use of medical personnel at the initial decision stage, as does the Social Security Administration.[3]

There is no doubt that medical personnel can offer valuable assistance in making disability determinations called for by the Social Security Act. Notwithstanding the mixed medical and legal content of the Social Security Act's disability standards, most disability determinations require the resolution of medical issues in one form or another. At the same time, it must be recognized that doctors cannot simply apply their general medical expertise to the work of determining disability under a complex and multi-faceted statutory disability standard. Doctors are accustomed to evaluating a person's limitations in the context of treatment; they are oriented professionally to identify the cause of and resolve limitations, rather than to identify limitations and then measure them against stated requirements for receipt of benefits. These recommendations are intended to help reconcile the needs of the Social Security Administration disability determination process for medical expertise and the ability of the medical profession to meet those needs.

Medical personnel perform three main functions in current practice. First, they assist in developing the medical records on which disability decisions are based. Second, they provide medical evidence for the record, including medical findings and opinions relating to an individual claimant's impairments and explanations of other medical evidence already in the record. Third, they participate in making disability decisions at the initial and reconsideration levels based on the record.

Each of these functions suggests models for using medical decisionmakers in Social Security disability determinations. The first model would increase the responsibility of

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[1] If it is thought that current law precludes such a State Department study, Congress should authorize the State Department to undertake the study.

[1] See Recommendations 78-2 (ALJ hearing stage), 87-6 (state level determinations), 87-7 (Appeals Council).

[2] For cases involving mental impairments, Social Security regulations provide that either psychologists or psychiatrists may assist in determining disability. Accordingly, references to the terms "medical sources," "physicians," and "doctors" in these recommendations are intended to include psychologists used in those cases.

[3] While the Conference has examined the other federal disability programs and believes that these recommendations hold valuable lessons for the agencies administering those programs, these recommendations are addressed solely to the Social Security Administration.

medical personnel for compiling all relevant medical evidence. Medical personnel would concentrate on evaluating the adequacy of the record and following up with requests for clarification and additional information from treating and consulting medical sources. Medical personnel would also be given specific responsibility for assuring that all medical evidence in the record is clear and understandable to both medical and non-medical decisionmakers. The second model would improve the use of doctors as sources for supplying medical data and opinions on which disability decisions can be based. This model also supports the use of medical personnel to evaluate and resolve certain specified medical issues relevant to a claim if, in a particular case, there are medical issues that can be identified as appropriate for separate decision. The third model would make more effective use of medical personnel in decisionmaking role. This model would concentrate medical resources at the initial decision level, where a doctor would share the responsibility for decisionmaking with a non-medical disability examiner. The doctor member of the team would be given special responsibility for certain tasks, and would undertake a full and independent review of the entire record in each case. The expectation is that through open exchange of information between the two decisionmakers and a reasonable allocation of responsibility based on each member's expertise, most disability determinations will be made by consensus. If conflicts arise on medical issues, separate medical personnel would be given the authority to resolve those conflicts.

The following recommendations would implement the important provisions of each of these models. Implementing these recommendations would require greater expenditures for medical personnel and related support at the state agencies. However, additional costs should be offset by savings resulting from elimination of the reconsideration level and reduced numbers of administrative and federal court appeals.

Recommendation

A. Improvements at the Initial Decision Level

The Social Security Administration (SSA) should enhance the decisionmaking role of medical personnel at the initial decision level. This can be accomplished by improving upon the current practice of using two-member teams—consisting of a medical member who is a licensed physician or psychologist and a non-medical member who is a disability examiner—to determine disability, as follows:

1. *Responsibility for developing medical evidence.* SSA should ensure that the medical member of the team is given primary responsibility for developing the medical evidence[*] in the record.

(a) Staff and resources should be allocated so as to assure that a complete record of all evidence relevant to a disability claim is obtained before an initial decision is made on the claim.

(b) Specially trained support staff, including nurses and non-medical personnel, should be made available to assist the medical member in developing the medical evidence.

(c) The medical member should, whenever possible, be assigned direct responsibility for evaluating the adequacy of reports from physicians and for following up with requests for clarification or additional information from these sources.

2. *Identifying and deciding discrete medical issues.* SSA should develop a list of discrete issues raised by the applicable disability standards that may arise in individual claims and that are appropriate for decision by medical staff. The medical member of the team assigned to a claim should be made responsible for identifying any such discrete issues raised in the claim, developing all evidences relevant to the issue, and reaching a decision on that issue.

3. *Resolving medical conflicts.* SSA should ensure that medical personnel are used to resolve any conflicts on medical issues that arise in the course of team evaluations of disability at the initial decision level.

(a) Senior medical staff should be given the authority to review claims where the team members are unable to agree and to recommend further

[*] "*Medical evidence*" includes (1) medical findings and opinions relating to an individual claimant's impairments, (2) other evidence, including subjective symptoms, that is relevant to determining the existence or severity of the claimant's condition, and (3) explanations of other medical evidence already in the record. The recommendations' focus on development of medical evidence is not intended to minimize the importance of the development of other evidence, including vocational evidence.

action, including the development of additional medical evidence, to resolve the conflict.

(b) If the conflict persists, the state agency's medical personnel should assume primary responsibility for evaluating the record with respect to the medical issues and for making a determination based on that record.

(c) As part of this process, independent medical experts, or panels of experts, should be identified and retained for use as examining and non-examining consultants, as appropriate.

4. *Notice of deficiencies in medical evidence.* SSA should require that claimants be informed specifically of any deficiencies in the medical evidence that could lead to an adverse determination before the initial decision is made.

(a) This notice should be prepared by the medical member of the team, should clearly explain any deficiency in the medical evidence, and should encourage the claimant to provide additional information and explanation, as needed. This notice should also state that the agency will assist claimants in obtaining this information when they are unable to do so on their own due to financial or other constraints.

(b) As part of this process, either the claimant or the medical member should have the authority to initiate a face-to-face interview.

5. *Ensuring quality of evidence.* SSA should take steps to improve the quality of evidence provided by medical sources for disability adjudications.

(a) Guidelines should be established that identify priorities for the use of treating physicians, examining physicians and non-examining physicians, including specialists, for these purposes.

(b) Selection and evaluation of physicians asked to provide medical information should be performed by medical personnel independent from the agency staff responsible for making disability decisions and should be supported by a system for quality control covering both the selection of physicians and the reports submitted.

(c) Physicians asked to provide medical information should be adequately compensated and should be provided with instructions as to applicable agency standards.

(d) Medical personnel should be able, when appropriate, to consult with specialists before ordering examinations or tests.

(e) All contacts with medical sources relating to the determination of disability for a particular claim should be documented routinely in writing and included in the record. SSA should ensure that claimants are provided a copy of any reports prior to issuance of the decision and accorded an opportunity to object and rebut appropriately.

6. *Training and supervision of medical personnel.* SSA should ensure that all medical personnel are trained fully on legal and program issues and work under the supervision of the chief medical officer in the state agency. SSA should also ensure that medical staff act in accordance with the rules established by the Social Security Act and relevant federal court decisions, including the requirement to obtain and give appropriate weight to the opinions of claimants' treating physicians, in performing the functions described in paragraphs 2, 3(b), and 5(a).

B. Reconsideration

7. *Elimination of Reconsideration.* SSA should seek to concentrate the efforts of the disability determination team on a single initial decision process, as outlined in these recommendations. Together with implementations of these recommendations, the separate reconsideration stage should be eliminated.

C. Appeal Level

8. *ALJ use of medical experts.* SSA should encourage its administrative law judges to call on an independent medical expert in appropriate cases to assess the need for any additional medical evidence and to explain or clarify medical evidence in the record.[8]

[8] SSA should also ensure that its ALJs receive appropriate training on medical issues relevant to their decisional responsibilities.

Admin. Conference of the United States

SSA should make clear by regulation that a medical expert's evidence can be presented orally or in writing. The regulations should also provide that claimants are notified of the inclusion of an expert's report in the record and should assure that claimants' rights to object to the inclusion of the report, submit rebuttal evidence, and cross-examine the expert are not abridged. The regulations should also provide that all information and opinions provided by medical experts must be included in the record.

[54 FR 53496, Dec. 29, 1989]

§ 305.90–4 Social Security Disability Program Appeals Process: Supplementary Recommendation (Recommendation 90–4).

The Administrative Conference of the United States has undertaken numerous studies over the years relating to the appeals process in the Social Security Administration (SSA) disability program. It has issued four recommendations specifically involving the various levels of review in that program. It has also issued other more general recommendations involving various aspects of adjudicatory procedure. This Recommendation is intended to supplement those previous recommendations to reflect the passage of time and experience. It is consistent with previous recommendations, but in some cases, it goes further, or makes suggestions in areas previously left unaddressed. Unless specifically noted, existing recommendations have not been superseded, and their provisions will not be repeated in this Recommendation.

The SSA disability appeals process involves several steps. The initial determination of disability is made by federally-funded state Disability Determination Services (DDS). A dissatisfied claimant may seek a reconsideration by a different individual in the DDS. This reconsideration decision is appealable to an administrative law judge (ALJ) in SSA's Office of Hearings and Appeals, who holds a hearing on issues on appeal. If the claimant continues to be dissatisfied, he or she may appeal to the Appeals Council, which reviews the case and may in some instances permit supplementation of the record. Judicial review in the United States district court is available from an Appeals Council decision, which is considered to be final agency action.

PRIOR RECOMMENDATIONS

In 1978, ACUS issued Recommendation 78-2, *Procedures for Determining Social Security Disability Claims*, 1 CFR 305.78-2, which primarily addressed the administrative law judge stage of the Social Security disability program. It recommended the continued use of ALJs, and made suggestions concerning the development of the evidentiary hearing record, including recommending that ALJs take more care in questioning claimants, seek to collect as much evidence prior to the hearing as possible, make greater use of prehearing interviews, and make better use of treating physicians as sources of information.

In 1987, ACUS issued two recommendations relating to the disability program. Recommendation 87-6, *State-Level Determinations in Social Security Disability Cases*, 1 CFR 305.87-6, addressed the first level of determination and review in the disability program. Recommendation 87-7, *A New Role for the Social Security Appeals Council*, 1 CFR 305.87-7, addressed the organization and function of the Appeals Council. Recommendation 87-6 was based on early results from demonstration projects involving the state-level disability determination process. It recommended additional experimentation with face-to-face procedures. Recommendation 87-7 suggested wide-ranging and substantial changes in the workings of the Appeals Council, including that it move away from its historical primary function as a case review panel. The recommendation suggested that the caseload be significantly limited, and that the Appeals Council focus on important issues on which it could issue precedential opinions.

In 1989, ACUS issued two further recommendations affecting the disability program. Recommendation 89-10, *Improved Use of Medical Personnel in Social Security Disability Determinations*, addresses a variety of issues involving medical decisionmaking at the state-level determination stage. It proposes enhancement of the role of medical decisionmakers, increased effort to develop medical evidence in the record, and improved training of medical staff on legal and program issues. It recommends use of optional face-to-face interviews and elimination of the reconsideration step. It also recommends that claimants be informed of deficiencies in the medical evidence prior to the issuance of a state-level determination, and that the opinion of a claimant's treating physician be given the weight required by court decisions and SSA rules. In addition, Recommendation 89-8, *Agency Practices and Procedures for the Indexing and Public Availability of Adjudicatory Decisions*, recommends that agencies index and make publicly available adjudicatory decisions of their highest level tribunals, and further suggests that agencies not treating decisions as precedential reexamine those policies. This general recommendation would apply to the SSA Appeals Council.

Supplementary Recommendation

In 1989, the Social Security Administration asked the Administrative Conference to prepare a report that would describe the SSA disability process, review the relevant statutes, compare the process with disability programs under other statutes, and synthesize the relevant ACUS recommendations. The following supplementary recommendations are suggested by this report. These recommendations are consistent with the spirit, and in most cases, also with the letter of previous recommendations described earlier, but they address issues that have heretofore not been addressed by the Conference or have been addressed in a manner for which additional refinement is appropriate.

Decisions on social security claims that are issued at each level of the process need to contain information sufficient to allow the claimant to make an informed decision whether to appeal to a higher level. It is therefore important that the basis for the decision, including the facts found, be stated clearly. Further, where the record appears not to be complete, the decision should indicate what information is lacking, so that it can be provided at the subsequent level. These suggestions apply both to the initial decision at the state level and to the ALJ decision. The Conference recognizes that SSA rules already require most of this information in ALJ decisions, but more consistent implementation of these rules is needed.

The Social Security Act provides claimants the right to subpoena witnesses and information. Moreover, the Supreme Court made clear in *Richardson v. Perales*, 402 U.S. 389 (1971), that the availability of subpoenas may be critical to a claimant's ability to present relevant evidence. However, subpoenas are seldom issued in disability proceedings. The Conference believes that ALJs should be encouraged to issue subpoenas, and that claimants should be encouraged to seek them to complete the record. While the Conference recognizes that concerns exist about effective enforcement, it believes that such concerns should not prevent the issuance of subpoenas, and that enforcement issue should be addressed separately. If enforcement of subpoenas appears to be a problem in the future, the Conference will consider studying the issue separately.

Prehearing conferences at the ALJ level could be used to streamline the hearing process by narrowing issues and ensuring the necessary evidence will be available at the hearing; in some cases the prehearing conference may eliminate the need for a hearing. However, such conferences should not be used to discourage claimants from seeking a hearing. Nor, except in rare cases, should they be used in cases involving *pro se* claimants, who might unknowingly waive rights or later opportunities to present evidence.

The Conference believes it is important that the evidentiary record be as complete as possible as early in the process as possible. It believes that the increased use of subpoenas will make this possible, in conjunction with the

provision in Recommendation 89-10, ¶ 5(c), that physicians asked to provide medical information in disability proceedings be adequately compensated. If a claimant is informed by the ALJ what information is still needed after the hearing, and is given an opportunity to supplement the record at that time, the need to supplement the record after the ALJ hearing should decrease.

The Conference is also recommending that the record before the ALJ be closed at a set time after the hearing. The procedure would give the claimant sufficient time to acquire such information as is needed to complete the record, and would also provide for extensions of time upon a showing of good cause.

As a corollary to this, the Conference is recommending that a procedure be developed for the ALJ to reopen a record upon petition by the claimant where there is new and material evidence relating to the period covered by the hearing. Such petitions could be filed within one year of the ALJ decision or while the case is pending before the Appeals Council if it has been appealed.[1] Under such a procedure, new evidence would be considered first by the ALJ, thereby giving the adjudicator most familiar with the case the first opportunity to review new evidence, potentially reducing the number of cases that would be presented to the Appeals Council, and giving the Appeals Council more of an appellate role. *See generally* Recommendation 87-7. The ALJ's decision not to reopen should be appealable to the Appeals Council. If the Appeals Council finds that new and material evidence did exist, it should generally remand to the ALJ for consideration of the evidence, except where substantial injustice or unreasonable delay would result.

These recommended procedural changes are not designed to limit the record in a disability case, but rather to impose additional structure on the process, by clarifying the rules and encouraging the timely production of evidence. It is expected that these changes will result in evidentiary records being completed in a more timely and efficient manner, thereby increasing the quality of the decisions based on those records.

The issues addressed in paragraph 5 of the recommendation, discussed above, were considered in Recommendations 78-2(C)(1) and 89-7(1)(c)n.2 These previous provisions are subsumed within this Recommendation.

RECOMMENDATION

The Social Security Administration (SSA) should make the following changes in the disability determination and appeals process:

1. *Contents of Decisions:* SSA should require that disability benefit decisions, both at the state-level determination stage and at the administrative law judge stage, clearly provide in language comprehensible to claimants at least the following information:

a. The date the application for benefits was filed.

b. The date of onset of disability as alleged by the claimant.

c. The date of onset of disability, if any, that has been determined by SSA.

d. The period of time or category for which benefits have been denied, if any. Where benefits have been awarded for one period or category and denied for another period or category, the notice should clearly state that benefits have been partially denied.

e. If any category of benefits has been denied for any period, a list of evidence considered, and an explanation of why benefits were denied, including why the evidence of record did not support the grant of benefits.

f. The date of expiration of claimant's disability insured status (i.e., the "date last insured").

g. The adverse consequences, if any, including preclusive effects, that will result from failure to appeal the decision.

2. *Prehearing Conferences:* The use of prehearing conferences should be encouraged in appropriate cases to frame the issues involved in the ALJ hearing, identify matters not in dis-

[1] These proposed procedures are distinct from the supplementary to SSA's generic "reopening" procedures set forth at 20 CFR 404.987-404.989; 416.1487-89.

pute, and decide appropriate cases favorably without hearings. Except in rare cases, such conferences should be held only where claimants are represented by counsel, and they could be held over the telephone where will parties agreed. A report on the conference, reflecting any actions taken, should be included in the record. Issues that should be considered at a prehearing conference include:

a. Additional information that is required.

b. Subpoenas that may be necessary.

c. Witnesses that may be required.

d. What issues are or are not in dispute.

3. *Subpoenas:* Administrative law judges' use of their subpoena power should be encouraged. Subpoenas should be issued *sua sponte* where necessary to ensure that medical evidence is complete, and to obtain other necessary evidence not otherwise available. Subpoenas should be issued when requested by the claimant except where the ALJ finds good cause not to issue a particular subpoena. SSA should develop form subpoenas for use by disability claimants, and provide instructions for their use. This recommendation is to be read in conjunction with Recommendation 89-10, *Improved Use of Medical Personnel in Social Security Disability Determinations.*

4. *Closing of the Administrative Record:* The administrative hearing record should be closed at a set time after the evidentiary hearing. Prior to this, the ALJ should set forth for the claimant what information the claimant needs to produce to complete the record, issue any necessary subpoenas, and provide the claimant adequate time to acquire the information. Requests for extension should be granted for good cause, including difficulty in obtaining material evidence from third parties. The ALJ should retain the discretion to accept and consider pertinent information received after closure of the record and before the decision is issued.

5. *Introduction of New Evidence After the ALJ Decision:* a. Upon petition filed by a claimant within one year of the ALJ decision or while appeal is pending at the Appeals Council, the ALJ (preferably the one who originally heard the case if he or she is promptly available) should reopen the record and reconsider the decision on a showing of new and material evidence that relates to the period covered by the previous decision. An ALJ's denial of such a petition should be appealable to the Appeals Council.

b. Appeals Council review of an ALJ's initial decision should be limited to the evidence of record compiled before the ALJ. Where the claimant seeks review of an ALJ's refusal to reopen the record for the submission of new and material evidence, the Appeals Council should remand the case of the ALJ (preferably the one who originally heard the case if he or she is promptly available), if it finds that the ALJ improperly declined to reopen the record. The Appeals Council should not review the merits itself or issue a decision considering the new evidence, unless remand would result in substantial injustice or unreasonable delay.[2]

[55 FR 34213, Aug. 22, 1990]

Chairman JACOBS. Thank you, Mr. Breger.
Mr. Pickering.

STATEMENT OF JOHN H. PICKERING, CHAIRMAN, COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, AMERICAN BAR ASSOCIATION

Mr. PICKERING. Thank you, Mr. Chairman.

I appear for the American Bar Association, to state its general support for H.R. 1799, and to suggest additional improvements in the Social Security disability review process.

I have a prepared statement which I request be placed in the record, along with the association's resolutions attached to it, and the accompanying explanatory reports which have been given to the committee staff.

Chairman JACOBS. Without objection, it will be included.

Mr. PICKERING. The ABA has had a longstanding interest in the disability review process, because, as the committee knows, the quality of decisionmaking in this area has a profound effect on the lives of millions of Americans. We have devoted much attention to this important matter and we have worked with other organizations, such as the Administrative Conference of the United States, to improve the process.

The ABA supports the general intent of H.R. 1799, but we believe it should be made stronger. Specifically, while we support the bill's provisions for face-to-face interviews and for improving the quality of the patient's files at the initial stage, we have two improvements to suggest in these provisions.

First, the Social Security Administration should be directed to take affirmative action to complete the necessary documentation in support of the claims at the initial stage. Many of these claimants are simply unable, for various reasons, such as linguistic or cultural barriers, financial constraints or the limitations of their own disabilities, to bear the burden of producing all of the necessary information.

Second, H.R. 1799 should require that the claimant's pain and residual functional capacity be assessed by his or her own physician, before an initial determination is made. All too frequently, consultative reports service as the basis for disability determinations which are often successfully challenged as wrong.

The association does not have a formal position on the third point of the bill, which would abolish reconsideration at the State level. However, if the quality of the initial intake process is improved, as the bill provides and we support, there would seem to be little reason for keeping the reconsideration process.

While we support H.R 1799 as a step in the right direction, there are several additional fundamental changes that should be made for further improving the disability review process.

First, the Social Security Administration must be required to stop its policy of nonacquiescence to the decisions of Federal Courts of Appeals. The association has repeatedly condemned this nonacquiescence practice and has called for legislative action to ensure that the Social Security Administration adheres to the basic legal principle that court precedence should be followed.

Second, claimants should be provided with clear and accurate information about the elements of proof in disability claims before any action is taken. They should receive a report of the status of their file, along with copies of any records placed in their files by the Government or any third party.

Third, the administrative law judge's decisional role should be protected, and the proceedings should be nonadversarial. The association supports legislation to ensure judicial independence and efficiency of Federal administrative law judges, including having a separate corps of judges.

Fourth, we have concerns about the role of the Appeals Council in the review process, as does the Administrative Conference of the United States. We, accordingly, believe that consideration should be given to abolishing or radically restructuring the functions of the Appeals Council, as has been recently suggested by the Federal Courts Study Committee.

Finally, the ABA is strongly opposed to various proposals that have been made to create a special article I court to review disability claims. We believe that review function should remain in the Federal District Courts, for the reasons given in my prepared statement. I may say that it was the Federal District Courts that unearthed the abominable practice laid bare, finally, in the *Bowen* case, where, sub rosa, desk drawer policies were used to deny disability benefits to roughly 25,000 people, a matter which was affirmed when it reached the Supreme Court, 9 to 0, with Justice Powell writing a stinging opinion about how the Social Security Administration handled them.

We do not believe that an article I court could perform this necessary review function, so we urge that it stay in the District Court.

Thank you very much. I will be glad to answer questions.

Chairman JACOBS. Thank you, Mr. Pickering.

[The prepared statement follows:]

STATEMENT OF JOHN H. PICKERING
AMERICAN BAR ASSOCIATION

Mr. Chairman and Members of the Subcommittee:

My name is John Pickering, and I chair the American Bar Association's Commission on Legal Problems of the Elderly.

On behalf of the ABA, I would like to thank the Subcommittee for the opportunity to appear before you today to discuss the ABA's views on reform of the disability review process, and in particular, HR 1799.

One of the world's largest voluntary professional organizations, and a representative of the legal profession in the United States, the American Bar Association has long been concerned with equal access to justice for the disenfranchised, the elderly and the disabled, those members of our society who are generally least able to protect their own rights. The Commission on Legal Problems of the Elderly was created in 1978 by the ABA Board of Governors to analyze and respond to law-related needs of older Americans, one of which is to improve the administrative process available to aggrieved Social Security claimants to ensure that it is both efficient and fair. As you know, the quality of decisionmaking in this area can have a profound effect on the lives and well-being of millions of Americans. For many claimants, these benefits constitute their only source of income and access to health care.

The American Bar Association has had a long-standing interest in the disability review process. In 1985 the ABA and the Administrative Conference of the United States (ACUS) held a symposium to discuss the administrative appeals process available to Social Security claimants. The symposium produced a set of recommendations that resulted in the formation of an extensive policy statement adopted by the ABA House of Delegates in August 1986. Also in 1986, the Association filed an amicus curiae brief in the landmark United States Supreme Court case, Bowen v. City of New York, 476 U.S. 467 (1986), in which the Association successfully argued that the Social Security Administration should reopen the cases of thousands of mentally disabled claimants who were denied disability benefits because they failed to meet appeal deadlines. Brief for the American Bar Association, Amicus Curiae, in Support of the Respondents, Bowen v. City of New York. Since then, in 1988 and again in 1990, the ABA has adopted policies aimed at improving the Social Security Administration claims process and protecting the rights of beneficiaries. Statements of those resolutions are attached. Copies of the accompanying reports have been distributed to the Subcommittee.

My understanding is that the purpose of this hearing is to address the problem of how to enable an already overburdened Social Security system to handle effectively and efficiently an ever-growing number of disability appeals. Although the current appeals process is, indeed, not as efficient and effective as it might be, it is important to recognize that it does as a whole meet the needs of disability claimants who benefit from the flexibility that the current system provides. Any reforms, therefore, must retain this flexibility -- indeed, expand it -- if they are to satisfy the letter and spirit of the Social Security Act.

Both the increase in appeals of benefit denials and the large number of reversals of these denials indicate that attention should focus on ensuring that accurate decisions are made at the initial application stages. The accuracy of these decisions is the absolute key both to the smooth functioning of the system and the well-being of claimants, many of whom have no other source of income.

While the ABA supports the general intent of HR 1799 which is before you today, we are concerned that (a) it does not go far enough toward alleviating many of the delays and inaccuracies of the disability claims process and (b) that it may impose an undue burden on a claimant who is unable to compile essential documentation of his or her disability.

The ABA supports the bill's goal of face to face interviews and improving development of the claimant's file during the initial stages of the disability process. It is clear that the current failure to do so contributes to the high rate of initial denials, and consequent reversals on appeal. However, we are concerned that the claimant will continue to bear the burden of producing the necessary information. Many persons eligible for disability benefits are unable even to apply without assistance. Linguistic and cultural barriers, to say nothing of financial constraints and limitations imposed by disability, severely restrict their means to obtain necessary records. The Social Security Administration should be directed to take affirmative steps to compile this documentation.

We wholeheartedly support efforts to improve the quality of the medical and vocational evidence at this stage of the process. Reports of treating physicians are usually the most valuable and accurate evidence of disability and should be given special weight. When those reports are not sufficiently detailed or comprehensive, the Social Security Administration should make vigorous efforts to supplement them.

But, we are particularly concerned that HR 1799 does not require the claimant's pain and residual functional capacity to be assessed by his or her treating physician before an initial determination is made. Such assessments are vital to an evaluation of disability, and should not be limited to those performed only by consultative examiners. All too frequently consultative reports serve as the basis for a disability determination and all too frequently their medical conclusions are successfully challenged by claimants as inaccurate. In addition, consultative examiners should be provided with a claimant's medical records, when available.

The ABA does not have a formal position on abolishing reconsideration at the state level, which HR 1799 proposes. However, if the quality of the initial intake process is improved, as the bill provides, and we support, there would be little reason for reconsideration, particularly given the low reversal rate and delay involved at this level.

As I stated earlier, although HR 1799 is a move in the right direction, it does not go far enough toward instituting the fundamental changes necessary to improving the disability appeals process. As a preliminary and necessary step, the Social Security Administration must be required to abandon its policy of non-acquiescing to decisions of federal courts of appeals at all levels of the Social Security administrative process. The ABA has repeatedly condemned this practice, and in 1990 called for legislative action to ensure that the Social Security Administration adheres to the basic legal principle that court precedents should be followed. Ending this non-acquiescence policy will help ensure that standards for determining disability are consistent at all levels.

We would also support a requirement that claimants be provided with clear and accurate information about the elements of proof in a disability claim. Before any action is taken in a case, claimants should receive a report of the status of their file, along with copies of any records placed in their file by the government or any third party (including all reports made by consultative and treating physicians and other specialists or experts). Claimants should also receive notice

of any information not in the file, which normally would have been included. In our 1986 resolution, we recommended that the Social Security Administration consider a demonstration project to provide pre-hearing conferences as a way of educating claimants and ensuring that all of the pertinent evidence is in the record. Such a project might assist the agency and the claimants representatives in identifying the quirks in the system that perpetuate the large number of appeals.

With respect to the administrative hearing level, the current flexible procedures should be kept in place, and the administrative law judge's role as a factfinder should be protected. The ABA supports the judicial independence and efficiency of federal administrative law judges, including supporting in principal the enactment of legislation to establish a government-wide corps of administrative law judges. Because of this factfinding role, these hearings should continue to be conducted in non-adversarial settings.

We also have concerns about the role of the Appeals Council, and in 1986 called for a study as to whether Appeals Council review is needed. A subsequent study of the operations and utility of the Appeals Council, done for the Administrative Conference of the U.S., has raised many questions about continuing the Council as it presently exists.

The American Bar Association has consistently opposed legislation to create Article 1 courts to hear Social Security appeals for the reasons stated in our 1986 resolution to that effect, which are summarized below.

Although the Association appreciates this Committee's interest in improving the adjudicative process for reviewing these cases, it is the Association's position that the more significant problem is the failure by the Social Security Administration to accurately decide claims during the initial stages of the administrative process.

In the Association's past experience on this issue, it appears that efforts to establish a separate court to handle Social Security cases are motivated by three concerns.

The first is the increased number of appeals to federal courts by Social Security claimants, particularly by claimants challenging termination or denial of Social Security Disability benefits. Simply shifting all these appeals to another court system is not a practical solution. Additionally, the Administration's policy of non-acquiescence results in relitigating the same legal issues time after time within a circuit.

The total time and resources devoted by the district courts to these cases are not as substantial as the gross numbers would indicate. For example, in many, if not most, jurisdictions, Social Security appeals are initially considered by a Magistrate pursuant to an order of the Court. And, since a Social Security appeal involves the review of an administrative record for substantial evidence, there are no trials, no witnesses, and often not even oral argument.

The second reason often raised to justify an Article I court is that disability decisions are too technical for district court review. This argument fails for several reasons. Federal district courts do not conduct de novo hearings regarding factual issues about eligibility for benefits; rather, they review final decisions of the Social Security Administration to determine whether they are based on substantial evidence in the record. If unresolved factual questions arise, cases are remanded to the Social Security Administration. Indeed, federal courts issue far more remands

than reversals in these cases. Even assuming, arguendo, that these courts lack technical expertise in this area, the fact remains that they have decided tens of thousands of these cases in recent years. During the turbulent period 1981-1984, when the crush of litigation regarding Social Security benefits was at its peak, federal courts were instrumental in protecting claimants. They were one of the first objective forums to identify harmful SSA procedures, a benefit that will be absent in a specialized court, whose judges do not have the advantage of viewing these cases in the broader context of other types of claims.

The third rationale for the creation of a new court is the need for uniformity in a large national program such as Social Security. Despite the Association's empathy with the enormity of this problem, the creation of a special court is not the solution. It would be enormously expensive; it may cause hardship to claimants required to travel to distant hearings; it would not totally eliminate conflicts among the circuits, since existing federal courts would still be called upon to decide challenges to the constitutionality and legality of regulations; and, since many cases contain both disability and non-disability issues, a problem of appropriate forum arises. Finally, past proposals anticipated that a Social Security Court would establish its own rules of civil procedure. This hardly encourages judicial uniformity, and raises questions about the right to a hearing, the availability of injunctive relief, and whether class actions would be permitted.

I appreciate the opportunity to express the Association's views on these issues, and support the Committee's goals of improving the disability claims process.

Thank you.

Resolution of the

AMERICAN BAR ASSOCIATION

adopted by

the House of Delegates

August 1985

BE IT RESOLVED, that the American Bar Association urges the Social Security Administration to cease its policy of "nonacquiescence" within each circuit in decisions of the United States Court of Appeals within that circuit with respect to interpretation of the Social Security Act and regulations thereunder.

BE IT FURTHER RESOLVED, that the American Bar Association urges that, in the event that SSA continues its nonacquiescence policy, Congress enact legislation to mandate SSA to observe within each circuit the decisions of the Court of Appeals within that circuit, subject to seeking review in the United States Supreme Court.

Please note: The purpose of this report is to provide background information. Only the resolution constitutes official ABA policy.

REPORT

The Recommendation addresses a matter of serious concern to the public and to the bar - the practice of the Social Security Administration (SSA) in disregarding within a circuit the rulings of the Court of Appeals of that circuit in administering the disability and other programs under its jurisdiction. Thus, if a Court of Appeals rules that SSA has erred in its interpretation of the law in denying benefits to a claimant, SSA will give the claimant his benefits. But it will not follow the judicial interpretation in determining the entitlement to benefits of any other claimant in that circuit. Moreover, SSA will not ask for rehearing en banc in the circuit, nor will it ask the Supreme Court to review the Court of Appeals decision.

In other words, any claimant to benefits in that circuit who is entitled under the interpretation of the law to those benefits must exhaust his administrative remedies and then go to court in order to obtain them. As one district court observed: "If such a claimant has the determination and the financial and physical strength and lives long enough to make it through the administrative process, he can turn to the courts and ultimately expect them to apply the law ... If exhaustion overtakes him and he falls somewhere along the road leading to such ultimate relief, the nonacquiescence and the resulting termination stand." Lopez v. Heckler, 527 F. Supp. 26 (D.C.C.D. Calif., 1983). These claimants are the aged and the infirm, the people who cannot afford to challenge the government this way.

SSA, of course, claims expertise in the administration and interpretation of the laws under its jurisdiction. It claims that the federal courts misinterpret those laws. It may well be right with respect to particular cases; it may well be wrong. Those claims are wholly irrelevant with respect to the validity of, the justice of, its nonacquiescence policy.

In a judicial system, such as our federal court system, with its twelve regional appellate courts and multiple trial courts, the achievement of a consistent interpretation of law is a necessary and a difficult goal. Resolving conflicts among and between lower courts is one of the "essential functions" of the Supreme Court, to use then-Professor Frankfurter's term. Thus, conflicts between and among the circuits in a matter of federal law constitute one of the primary considerations which the Supreme Court looks to in granting review of decisions. The Court places great value upon "percolation" of issues through the lower courts in aiding it in arriving at a thoroughly considered analysis of a legal question. Therefore, the Government, as well as private parties with the ability to do so, when it loses a case in a Court of Appeals will seek a contrary ruling in another circuit, with the ultimate expectation of having the Supreme Court resolve the conflict. The Supreme Court recognizes and values this practice of percolation and supports it by generally refusing to apply collateral estoppel against the Government and allowing it to continue to litigate in different circuits issues it has lost in one or more circuits. United States v. Mendoza, 104 S. Ct. 568 (1984).

SSA's nonacquiescence practice may not claim the support of this policy, however. What SSA does is to refuse to follow within a circuit the decisions of that circuit. This practice is, to say it bluntly, lawless.

Just as it is the function of the Supreme Court to maintain consistency by resolving intercircuit conflicts, a function of each circuit is to resolve, or, more accurately, to prevent, intracircuit conflicts. The en banc circuit is responsible for deciding the law of that circuit with finality, subject only to Supreme Court review. But each circuit has a policy rooted in rule or decision to prevent conflicts between and among panels. In each circuit, it is the policy that once a panel has made a decision, no other panel may depart from that decision, and disagreement with the panel decision must be taken to the en banc circuit for definitive resolution.

When, therefore, a Court of Appeals panel resolves a matter of interpretation against SSA, that is the "law of the circuit" for that circuit, until and unless the en banc circuit court rules otherwise. Once SSA has lost a decision in a circuit, it will lose every other case governed by that decision before any panel of the circuit. The only legitimate recourse for SSA is to petition for en banc review or to petition for Supreme Court review.

Yet, SSA now routinely announces and advises its administrators and its ALJ that it does not "acquiesce" in a particular decision, compelling every claimant to fight all the way to a panel decision, through a tiresome and truly-named "exhaustion" of administrative remedies and through the courts. SSA does not petition for an en banc court (in fact, its rationale of nonacquiescence applies equally to en banc Courts of Appeals decisions) or for Supreme Court review. Any claimant who manages to hang on until he gets to the Court of Appeals will prevail. But great numbers cannot hang on.

This SSA practice must be condemned because:

(1) It works a manifest injustice to every claimant entitled to the application of a judicial decision, and these claimants are among the people least able to challenge the Government's conduct.

(2) It flouts the rule of law, because even a government agency is bound by a judicial decision. Nullification is no more an acceptable policy for the Federal Government than it is for the States or for individuals.

(3) It needlessly and unjustifiably adds to the caseload of the federal courts, already quite heavy, thus denying to other litigants, private and governmental, the opportunity for more rapid resolution of their cases.

SSA's policy has been condemned by numerous courts, although the United States Supreme Court has not had occasion to address it. The House of Representatives in H.R. 3755, 98th Congress, the Social Security Disability Benefits Reform Act of 1984, would have required SSA to either apply the decisions of each circuit within that circuit or appeal to the Supreme Court. While expressing concern, the Senate did not include a similar provision, and the bill as it emerged from conference to be passed and signed into law did not include the House provision. The joint conferees in their report, however, called upon SSA to alter its policy and indicated an intention to follow closely future developments.

The Committee, therefore, proposes that the Association, through action of the House of Delegates, urge the Social Security Administration to abandon its nonacquiescence policy. Failing cessation of the policy by SSA, the Association would urge Congress to enact legislation to bring to a halt the SSA form of nonacquiescence.

We are aware that certain other agencies of the Federal Government from time to time have engaged in a similar policy. SSA appears to be the agency most consistently following the policy and, because of the needs of the claimants and their numbers, to be doing so to the greatest detriment to the public interest. Other units of the Association may wish to consider the practices of agencies in which they have interest.

The Committee cautions that we have not addressed and do not apply anything said herein to the policy of some agencies, notably the IRS but other entities as well, in nonacquiescing in decisions of one circuit in other circuits. These agencies follow the decisions with which they disagree in the circuits in which they are issued. While perhaps worthy of study, this form of nonacquiescence is far different from that of SSA.

The Committee believes that the SSA policy is demeaning of the law and of respect for the law. It visits grave problems and burdens upon people already burdened. It clogs the courts with cases whose outcome is already established.

We urge adoption of the recommendation.

Respectfully submitted,

Robert M. Landis, Chairman
Standing Committee on Federal
Judicial Improvements

Lyman M. Tondel, Jr.
Commission on Legal Problems
of the Elderly

July, 1985
1185b

Resolution of the

AMERICAN BAR ASSOCIATION

adopted by

the House of Delegates

August 1986

BE IT RESOLVED, that the ABA opposes the enactment of H.R. 4647, H.R. 4419 and similar legislation to create an Article I Social Security Court to hear appeals from final decisions of the Social Security Administration.

Note: The purpose of this report is to provide background information. Only the resolution constitutes official ABA policy.

REPORT

On a number of occasions in recent years, proposals have been introduced in Congress to create a new Article 1 court to hear Social Security appeals and to remove appeals of final decisions of the Secretary of Health and Human Services regarding Social Security claims from the federal district courts. In the 95th Congress, HR 8276 was proposed to create a special Article 1 court for appeals from Social Security

Administration (SSA) decisions relating to the factual issue of disability. In HR 5700, the 97th Congress would have created a broader Social Security Court, modeled on the Tax Court, to handle appeals under both the Old Age, Survivors and Disability Insurance and the Supplemental Security Income programs. Neither proposal passed. In the present 99th Congress, HR 4647 and HR 4419 have been introduced which would, among other things, establish a similar Article 1 court to review final decisions regarding Social Security claims of the Secretary of Health and Human Services. Only actions raising constitutional claims or challenging the legality of regulations of the Social Security Administration could be reviewed in federal district courts thereby eliminating the substantial evidence review traditionally available in those courts to the elderly, disadvantaged, disabled and persons of modest means that constitute the bulk of Social Security claimants. Judges of the new Court would serve for 10 years and be removed during the term only for incompetence, misconduct, neglect of duty, practicing law or disability. The Court could hear cases throughout the United States. Appeals from its decisions would be to the United States Court of Appeals for the Federal Circuit.

The ABA has supported the creation of new specialized courts only on rare occasions, (e.g., Federal Administrative Court, 1936, Trade Practices, NLRB and Tax Courts 1956). In 1971, the ABA urged that the Tax Court be constituted as an Article III court rather than an Article I court. Similarly, the ABA has also opposed efforts to limit the diversity jurisdiction of federal courts, efforts to create the Federal Circuit Court of Appeals, U.S. Claims Court and U.S. Court of Tax Appeals, and efforts to grant jurisdiction to hear cases that are now heard by regional Courts of Appeals to a proposed, new "National Court of Appeals." We believe the ABA should not depart from its historical reticence to remove subjects from the jurisdiction of Article III courts and that attempts to remove Social Security claims from the federal courts system are not justified. We therefore urge the ABA to adopt a policy opposing the creation of the proposed new court for SSA appeals, envisioned by HR 4647 and HR 4419.

Efforts to establish a separate court to handle Social Security cases appear to be motivated by three concerns: the increased number of appeals to federal courts by Social Security claimants, particularly claimants challenging termination or denial of Social Security Disability Benefits; the feeling that disability decisions are technical and complex and thus better suited for adjudication by a specialized court; and the need for uniform decisions in a national program. None of these rationales, however valid, justify the drastic and costly step of creating a new Article I court, nor are they properly addressed by that proposal.

A. INCREASED NUMBER OF APPEALS DOES NOT JUSTIFY A NEW COURT

It is true that the number of Social Security claims heard

by federal district courts has risen dramatically in recent years. In 1985, approximately 27,000 cases were filed in federal district courts, up from 7,800 in 1981. In 1984, federal courts reversed or remanded the decision of SSA in over 60% of the cases. "Operational Report of the Office of Hearings and Appeals," SSA Pub. No. 70-032 (9-84). However, it is likely that this is a temporary phenomenon, and the unprecedented reversal rate suggests, and the Commission believes, that the cure lies more with regulatory clarity, statutory observance, and decisional competence at agency levels than in a change in appellate forums.

A number of events converged to cause this dramatic rise in the number of appeals. The aggressive SSA program of continuing disability reviews (CDRs) between 1981 and 1984 to assess the continued eligibility of beneficiaries resulted in 491,000 people being notified that their benefits would cease. Because new eligibility standards were utilized, which were stricter than those in place when benefits were granted, many claimants whose health and ability to work had not improved were terminated from benefit status. Often these decisions were based on brief examinations by consultative physicians or a mere "paper review" of claimants' records. Understandably, this sparked an avalanche of requests for administrative hearings (not to speak of Congressional criticism and public outrage) and, once administrative appeals had been exhausted, appeals to federal district courts. Because many decisions to terminate benefits were based on SSA policy which was not contained in SSA regulations or, even worse, on "sub rosa" policies unpublished and unavailable to the public, the number of claimants whose benefits were reinstated was high. Also, because of these illegal policies, thousands of disability denials have been ordered reopened for SSA review. See recent Supreme Court decision in Bowen v. City of New York (United States Supreme Court No. 84-1923; decided June 2, 1986 unanimously affirming Heckler v. City of New York 742 F.2d 729 (2d Cir. 1984); 578 F.Supp. 1109 (1984). (The ABA filed a brief as amicus curiae on behalf of Social Security claimants in the Supreme Court in this case urging affirmance and pointing out how SSA action contravened the rule of law.).

The workload in federal courts was likewise increased by the Social Security Administration's policy of non-acquiesence, criticized and opposed in ABA Report 110, 1985. According to this policy, which SSA has largely abandoned in federal courts, SSA continued to relitigate legal issues within the circuit which had already been decided by the Circuit Court of Appeals. See e.g., "Administrative Agency Intracircuit Nonacquiesence," 85 Colum. L. Rev. 582 (1985); H.R. Conf. Rep. No. 1039, 98th Congress., 2d Sess. 36-38 (1984).

This failure of administrative procedures to render credible and accurate decisions utilizing a process perceived by the public, attorneys and claimants to be fair and reliable has caused the enormous number of appeals to federal courts.

It is no justification for the creation of an entirely new court system.

First, although the number of appeals to the federal district courts has been quite large, the total time and resources devoted by the various districts to these cases is not as substantial as the gross numbers would indicate. For example, in many, if not most, jurisdictions, Social Security appeals are initially considered by a Magistrate pursuant to an order of the Court. Additionally, since a Social Security appeal involves an administrative record, there is no reason for the presentation of testimony or the utilization of excessive trial time. Indeed, many arguments are handled within one hour or less of oral presentation by counsel and are subsequently reviewed by the Court based solely upon the legal memorandum and the administrative record. As a result, the total amount of judicial time expended in resolving a case may be substantially less than in other types of cases. Furthermore, since a disability case can involve a total aggregate benefit amount of $75,000.00 to $100,000.00, the total amount of time spent upon such matters is well justified.

Furthermore, many of the practices which gave rise to the surge in the number of appeals have been corrected. In 1984, Congress enacted major legislation aimed at improving the process of determining eligibility for Social Security Disability benefits. (PL. 98-460) When fully implemented, this legislation is likely to reduce the number of appeals from Social Security claimants to federal district courts. The legislation:

(1) Requires uniform standards for disability to be applied at all levels of review;

(2) Requires creation of new procedures for Continuing Disability Reviews;

(3) Requires improvement of standards used to evaluate mental impairments;

(4) Sets temporary standards for evaluating the disabling effect of pain and requires a study of appropriate standards to use to determine how pain is to be weighed in determining disability;

(5) Requires that the cumulative impact of multiple impairments be considered and limits terminations of benefits of persons whose conditions have not medically improved.

When the effects of this new legislation take hold, the number of claims reaching federal courts is expected to decline significantly.

Similarly, SSA has in some respects abandoned its policy of

not abiding by circuit court precedent, at least in arguments before federal district courts. Cf. "Symposium on Federal Disability Benefit Programs Report and Recommendations," Appendix Comments of the Social Security Administration (1986).

Whether or not these dramatic reforms reduce the number of appeals to federal courts, reductions in the number of appeals to federal district courts can be achieved by measures less extreme and far less costly than creating an entirely new court system. In October 1985, the ABA, the Administrative Law Section, the Commission on Legal Problems of the Elderly, the Administrative Conference of the United States, Case Western Reserve School of Law and the Cleveland Foundation held a "Symposium on Federal Disability Benefit Programs." Among other conclusions, the Symposium found that significant problems are present both in the manner in which initial findings of disability are made and in the administrative appeals procedures available to claimants. The symposium recommended a package of improvements in the process utilized by the Social Security Administration to determine disability claims and process appeals. "Symposium on Federal Disability Benefit Programs Report and Recommendations," (1986). If implemented, these recommendations would result in more accurate decisions regarding eligibility for disability benefits, improve the credibility of administrative review procedures, and thereby reduce the number of cases which reach federal courts. A separate resolution asks for the ABA to endorse and support these recommendations. (See Report No. 127A).

In light of the fact that the number of cases reaching federal courts is likely to decrease and that other viable alternatives exist for improving the procedures used to determine eligibility for benefits, it is difficult to justify the enormous cost of a new bureaucracy necessary for a new Article I court system. At a time when the Congress is attempting to curb federal budget deficits, it seems unwise to enter on a costly new venture to deal with a phenomenon that may be an anomaly. Further, should a decrease in the number of Social Security claims occur, federal district courts would seem better able to absorb the decrease than a separate court would. Indeed, no tangible cost analysis underlies HR 4647 or HR 4419 -- a strange omission in today's fiscal context.

B. DISABILITY DECISIONS ARE NOT TOO TECHNICAL FOR DISTRICT COURT REVIEW

The second major rationale for proposals to create a disability court is that decisions about disability are particularly technical and complex and outside the expertise of federal magistrates and judges. Thus, it is essential that a separate court with special expertise is needed to assess medical evidence and make findings of disability. For example, in 1977, the Justice Department's Committee on the Revision of the Federal Judicial System proposed the creation of an Article I disability court based on the belief that "the indispensable

functions of the federal courts are the protection of individual freedoms, the interpretation of federal laws, and the preservation of democratic processes of government." The Committee suggested creation of an Article I tribunal to decide factual issues in SSA appeals thereby preserving the capacity of the Article III courts to respond to "claims of human freedom and dignity."

However, federal district courts do not conduct de novo hearings regarding factual issues about eligibility for benefits. Rather, they review final decisions of the Social Security Administration to determine whether they are based on substantial evidence in the record. 42 U.S.C. §405(a) (1982). The federal district courts, therefore, sit as appellate courts in SSA cases and do not substitute their judgment for the final decision of the Secretary of Health and Human Services. Therefore, the skills federal judges need to decide these cases are those they commonly utilize in dealing with administrative actions: weighing evidence and reviewing hearing records. Their review of technical medical issues is only to determine if there is a substantial basis for the decision. If unresolved factual questions arise, cases are properly remanded to the Social Security Administration, and, indeed the federal courts issue far more remands than reversals in SSA cases. Thus, the need for technical expertise is overestimated.

Even if it were once true, the argument that federal district courts lack the expertise to make disability determinations seems no longer valid. Federal court judges (and particularly magistrates, who hear the bulk of Social Security appeals) have in recent years decided tens of thousands of these cases. It is difficult to imagine that they have not developed a thorough understanding of the medical standards relevant to disability determinations which enables them to deal quickly and efficiently with Social Security appeals.

In addition, under HR 4419 and similar proposals, the federal district courts would retain the power to hear constitutional claims and claims which "constitute a challenge to any regulation of Social Security." HR 4647, 99th Congress, 2d Session. Many of the myriad of cases brought by claimants in the recent past raised due process questions (related to the appropriateness of the hearing procedures utilized) and challenged the manner in which Social Security had interpreted existing regulations. Should a similar crisis arise in the future, it is likely that the federal courts would again be called upon to review many of the cases which arise. Thus, in time of systemic stress the federal courts would still be called upon to hear a substantial number of cases relating to Social Security despite the existence of a separate court.

Further, the federal courts view Social Security claims within the broader context of other types of claims and bring an important objective perspective to the process. During the

turbulent period 1981-1984, when the crush of litigation regarding Social Security benefits was at its peak, federal courts were instrumental in protecting claimants. They were one of the first objective forums to identify harmful SSA procedures (which have since been largely abandoned). As the Supreme Court recently stated:

> ". . .the Secretary had the capability and the duty to prevent the illegal (SSA) policy found to exist by the District Court. The claimants here were denied the fair and neutral procedure required by the statute and regulations . . ." Bowen v. City of New York, No. 84-1923, decided June 2, 1986 Sl. op. at p. 19. (Holding that a class of some 50,000 mentally disabled claimants whose eligibility for benefits was assessed using an illegal procedure are entitled to a redetermination of their claims despite their failure to exhaust their administrative remedies or appeal their benefit denials to federal courts within statutory timeframes.)

See also, Mental Health Association v. Schweiker, 554 F.Supp. 157 (D. Minn. 1982), aff'd 720 F.2d 965 (8th Cir. 1983); (previously undisclosed policy denying certain mentally ill claimants an individualized determination enjoined); McLean v. Heckler, Civil Action No. 83-3429 (C.D. Pa. 1984) ("This case presents an appalling example of sheer bureaucratic dishonesty. The evidence shows overwhelmingly that the claimant is totally disabled. . .If the purpose of the United States Department of Health and Human Services is to crush defenseless human beings, as it seems to be, it would succeed unless in cases like this, courts interposed a protective arm.") These and other decisions exposing flaws in the SSA disability determination process underscore the benefits of objective review by the federal district courts, a benefit that might be absent in a specialized court.

C. A SPECIALIZED COURT WOULD NOT INSURE UNIFORMITY OF DECISIONS

The final rationale for the creation of a new court is the need for uniformity in a large national program such as Social Security. The Commission appreciates the complexity and the difficulty of trying to maintain consistency in a national program subject to precedents of eleven Circuit Courts of Appeal. The Secretary of Health and Human Services has a difficult task to administer efficiently and effectively a bureaucracy charged with both the responsibility to issue millions of checks each month and make hundreds of thousands of disability determinations annually and yet remain responsive to the legal interpretations that the circuits are issuing in this field.

Despite our empathy with the enormity of this problem, however, we still oppose the creation of a separate court to hear only SSA cases, appeals from which would be heard by the United States Circuit Court of Appeals for the Federal Circuit. While the proposed system would tend to ensure uniformity, it would be enormously expensive, it would not totally eliminate conflicts between the circuits (since challenges to the constitutionality and legality of regulations would still be decided within the existing federal courts) and it would undermine important values inherent in our current judicial system.

The current system, which allows Circuit Courts of Appeal to set precedent for their circuit until such time as the Supreme Court decides issues upon which circuits disagree, improves the quality of precedents. As the Circuit Courts of Appeal grapple with the hard issues which come before them, they can be informed by and expand upon decisions of other Circuits. When the Supreme Court decides an issue upon which Circuits have disagreed, it then has access to the best thinking on the issue and a number of well reasoned views on the subject. Thus, when the Supreme Court finally decides an issue, it is well informed and can consider all of the alternatives. This constant refining of issues before their final adjudication would be absent from the new Social Security Court system as proposed in HR 4647, HR 4419 and similar attempts to establish a separate court system.

In the past, the Social Security Administration has resorted to a policy of "non-acquiesence" to decisions of Circuit Court precedent within the Circuit. SSA justifies its failure to comply with the law of the Circuit by citing its need for uniformity. In ABA Report 110, 1985, the ABA condemned this practice. SSA has largely abandoned its policy of non-acquiesence at least at the federal district court level. Cf. "Symposium on Federal Disability Benefit Programs Report and Recommendations," Comments of the Social Security Administration, Appendix (1986). SSA is now in the process of beginning to attempt to comply with Circuit precedents. Just as the ABA opposed the SSA policy of non-acquiesence, despite SSA's considerable need for uniformity, also the ABA should oppose attempts to circumvent the judicial system which so wisely respects the process which occurs when different Circuits disagree on an issue.

Creation of a separate court system may cause additional hardship to claimants and their representatives. Most claimants for Social Security disability benefits have significant health related problems which can make travel to hearings particularly difficult. Even if members of a Social Security court would circuit-ride, unless enormous resources were expended, it seems unlikely that hearings could occur in every place where federal district courts currently sit. Many claimants and their representatives will have to shoulder the burden of traveling to places which may be quite distant to

present their cases and wait longer for an opportunity for a hearing. Thus, creation of a new court may have a significant adverse impact on access of these vulnerable individuals to the court system.

CONCLUSION

We, therefore, urge the ABA to oppose attempts to create a separate court to hear only appeals from final decisions of the Social Security Administration. Whether one is concerned with protecting claimants, preserving the current federal court system of review, holding firm against needless federal spending, or ensuring ease in the administration of the Social Security system, there is no reason to support attempts to create a separate federal court to handle appeals from final decisions of the Social Security Administration. Thus, the ABA should oppose HR 4647, HR 4419 and similar proposals.

Respectfully submitted,

John H. Pickering, Chairman
Commission on Legal Problems of the Elderly

David B. Wexler, Chairman
Commission on the Mentally Disabled

August, 1986

Resolution of

The American Bar Association

adopted by

The House of Delegates

August 1986

Be It Resolved, That the American Bar Association supports efforts to improve the administrative process utilized by the Social Security Administration in accordance with the following principles recommended by the Symposium on Federal Disability Benefit Programs.

I. *Further Clarification of Disability Standards*

A. The Social Security Administration (SSA) should continue its efforts to clarify the definition of disability through the issuance of regulations open to notice and comment. Issuance of these regulations should not be unduly delayed by the Office of Management and Budget's review process.

B. The standards utilized to determine eligibility should be consistent at all levels: in state disability determinations, SSA decisions (including ALJ determinations) and judicial decisions. To help ensure consistency, SSA should abandon its policy of intra-circuit non-acquiescence at all levels.

C. SSA should foster and participate in future symposia and other meetings between SSA officials (including ALJs) and practitioners and others involved in the disability process.

II. *State Level Procedures*

A. *Improve Quality of Initial Determinations*

1. The initial application intake process should be improved. Productivity guidelines and form questionnaires used by SSA must be revised to promote development of complete, accurate information during the initial intake interview with the claimant.

2. Strong emphasis should be given to improving the quality of state determinations so that fewer appeals will be necessary.

3. Better training should be given to state disability examiners, and emphasis should be placed on the quality, not simply the speed, of their determinations. More realistic assessments of ability to engage in substantial gainful activity should be made by state disability determination offices.

4. SSA should implement the Social Security Disability Benefits Reform Act of 1984 by pursuing and evaluating demonstration projects with face-to-face interaction between claimants and decisionmakers at the earliest practicable levels.

B. *Provide More Information to Claimants on Procedures and Burdens of Proof*

1. Claimants should receive, at the earliest feasible point, clear information regarding the elements which they must prove at each stage of the disability determination process (including ALJ hearing).

2. Before any action is taken in a case, claimants should receive a report of the status of their file, along with copies of any records placed in their file by the government or any third party. Claimants should also receive notice of any information not in the file, which under normal procedures would have been included.

3. In particular, claimants should receive copies of all reports made by consultative and treating physicians and other specialists or experts.

4. SSA should carry through its intention to publish, and make widely available, portions of the Program Operations Manual System (POMS) that are relevant to handling and deciding disability claims.
5. SSA should promulgate regulations on how determinations of medical equivalency to the listings of impairment should be made.

C. *Improve the Quality of Medical Evidence*

1. SSA should give special weight to the reports of treating physicians and should communicate that policy throughout the system.
2. Vigorous efforts should be made to obtain treating physician's reports. When a treating physician's report is not detailed or comprehensive enough, every practicable effort should be made to obtain a supplemental report from the treating physician, and claimants and their representatives should be notified of this policy.
3. SSA should increase efforts to educate the medical community regarding the eligibility criteria used in the disability program and the kind of medical evidence SSA requires, in order to increase the number of physicians capable of meeting SSA standards and requirements.
4. Consultative examiners should be held to the highest medical standards in communicating with, examining and diagnosing applicants. Their reports should also be required to conform to the highest standards. The examiners should note the length and extent of the examination on the report.
5. Consultative physicians should be provided with all prior medical records available. SSA should periodically audit the performance of consultative physicians based on the consistency of their reports with prior and later medical opinions.
6. SSA should reconsider the usefulness of the Department of Labor's Dictionary of Occupational Titles in accurately describing the existing relationship between medical conditions and vocational opportunities.

D. *Make the Quality Assurance Program More Constructive*

The SSA's quality assurance program should strive to operate with objective criteria and should be based on regulatory guidelines. It should not be used primarily as a means to cut the budget. It should not limit itself to merely remanding cases, but should promote a constructive dialogue within the decisionmaking process.

III. *Administrative Law Judge (ALJ) Hearings*

A. *Protect ALJ's Role as Factfinder*

1. Whether or not the claimant or government has a representative at the hearing, the role of the ALJ is special and should continue to require development of the factual record and close contact with the claimant. The hearing should not be conducted in an adversarial setting.
2. Performance reviews of the ALJs should be based as much on the quality of their product, as on the quantity of product.
3. SSA should ensure that staff attorneys be directly responsible to individual ALJs and that ALJs remain ultimately responsible for decisions. To that end, SSA should strive to hire sufficient staff attorneys so that individual attorneys are assigned to one or two individual ALJs.
4. Office of Hearings and Appeals (OHA) should continue to develop its practice and procedure manual for ALJ hearings.
5. SSA should encourage U.S. Attorneys to keep ALJs informed of all subsequent court actions pertaining to their decisions.

6. ALJs should be obliged to make individualized findings of fact that apprise claimants of the specific basis of decisions.

B. *Review Merits of Government Representation Project*

1. SSA should develop and disseminate more statistical data on the Government Representation Project, including its effectiveness and fairness to claimants, and should continue to regard it as experimental.
2. SSA should examine carefully the cost-effectiveness of continuing the Government Representation Project.

IV. *Appeals Council*

A. *Limit Scope of Review*

1. The Appeals Council's scope of review should be limited to clear errors of law or lack of substantial evidence for factual conclusions. Moreover, the ALJ's findings as to witness credibility ordinarily should not be subject to review. If the Appeals Council overturns factual determinations by ALJs, it should cite specific reasons for doing so.
2. ALJ findings of fact should never be reversed without a review of the tape recording of the hearing by the Appeals Council.

B. *Time Limit*

Congress should provide that if the Appeals Council does not act upon a request for review within a specified period of time, then claimants are deemed to have exhausted their administrative remedies and may seek review in federal district court.

Be It Further Resolved, That the American Bar Association urges a complete study of Appeals Council procedures and functions to determine whether Appeals Council review is necessary and to suggest any needed changes in its structure, methods of operation, delegation of authority, and role as policy maker.

The Commission's fourth recommendation (Report No. 126B) presented jointly with the Commission on the Mentally Disabled was approved by voice vote. It reads:

Be It Resolved, That the ABA opposes the enactment of H.R. 4647, H.R. 4419 and similar legislation to create an Article I Social Security Court to hear appeals from final decisions of the Social Security Administration.

Note: The purpose of this report is to provide background information. Only the resolution constitutes official ABA policy.

REPORT

I. THE ABA SHOULD ENDORSE THE CONSENSUS RECOMMENDATIONS OF THE SYMPOSIUM ON FEDERAL DISABILITY BENEFIT PROGRAMS

On October 11-12, 1985 leading jurists, government officials, academicians, representatives of Social Security claimants, and Congressional staff attended the Symposium on Federal Disability Benefit Programs cosponsored by the American Bar Association, the ABA Administrative Law Section and the Commission on Legal Problems of the Elderly, the Administrative Conference of the United States, Case Western Reserve School of Law and the Cleveland Foundation. The Symposium provided a forum for experts in the field to discuss the current system utilized by the Social Security Administration (SSA) to determine eligibility for Social Security Disability and Supplemental Security Income Benefits and the administrative appeals process available to claimants. Included in this report is the "Report and Recommendations" of the Symposium. That Report contains a summary of the conference discussions, recommendations upon which consensus was generally reached and comments of participants on the Recommendations.

Because one primary goal of the ABA is to improve the American system of justice, it is particularly important for us to study and make constructive suggestions for improving the administrative review process available to aggrieved Social Security claimants to ensure that it is both efficient and fair. The Social Security ALJ hearing system is the largest adjudicatory system in the world, holding more trial-type hearings annually than the entire federal court system. Social Security ALJs handle more than 275,000 appeals each year. In FY 1984, over 1,225,000 people applied for Social Security retirement or disability benefits.

Besides the sheer volume of administrative claims handled by the Social Security Administration, the quality of decisionmaking in this system can have a profound effect on the lives and well-being of literally millions of Americans. As we have seen in recent years, decisions to stop benefits can be actually "life and death" decisions in some cases, as individuals have died as a result of losing benefits. On the other hand, accurate decisions are needed to ensure that ineligible individuals do not receive benefits. As the federal government faces unprecedented federal deficits, it is extremely important that benefits are not granted to persons who do not meet statutory eligibility standards.

Therefore, the Symposium cosponsored by the ABA was of critical importance. It enabled a widely diverse group of experts, many of whom have been adversaries in court, to examine the SSA disability determination process and suggest changes.

The Symposium fostered the creation of thoughtful,

well-reasoned recommendations to form a foundation for ABA policy. The invited Symposium participants heard presentations on the following topics: initial determinations, reconsideration, ALJ hearings, the Appeals Council and alternatives to the current process. Panels comprised of experts with often competing or conflicting views discussed current practices and recommendations for change. Each panel was followed by lively discussion between panel members and participants. The Symposium provided a truly unique opportunity for partisans to air divergent views and to attempt to reach a consensus about extremely controversial issues.

The process produced a set of recommendations which were circulated to participants for review and comment. These recommendations, modified slightly in response to comments from participants, were largely agreed upon. It is important to observe that the Social Security Administration has endorsed most of the suggested changes in its procedures, with the exception of the recommendation to limit the scope of review of the Appeals Council (Comments of participants are appended to the Symposium Report and Recommendations in alphabetical order by the name of the commentor, with the exception of the joint comments of three participants from the Social Security Administration which are filed under the agency name.)

The Commission on Legal Problems of the Elderly commends the process used by the Symposium to reach these recommendations. Our review of their substance indicates that they form the basis for solid, needed improvements in the system. For a rationale for each proposal, refer to pages 2-13 of the "Symposium on Federal Disability Benefit Programs: Report and Recommendations" appended to this Report. We urge their adoption by the ABA, as called for by the first resolution submitted by this report.

II. THE ABA SHOULD ADOPT THREE ADDITIONAL RECOMMENDATIONS

The three additional recommendations submitted with this report cover additional matters which arose out of the recommendations from the Symposium. Because the Symposium recommendations are general as is typical of consensus resolutions, several, more specific, concrete recommendations have been prepared to provide the basis for clear ABA policy.

A. The Government Representation Project Should Be Abolished

The first additional and more-specific recommendation opposes continuation of the Social Security Government Representation Project (GRP).[1/] The GRP was initiated in 1982 as an "experiment" in four cities slated to last for one year to study the effect of participation of attorneys and others representing the Social Security Administration at administrative hearings. 47 Red. Reg. 36117, August 19, 1982. Despite the lack of conclusive data (or perhaps because of the

lack of conclusive data) the GRP is still operating four years later. The GRP was created by administrative action of the Social Security Administration and could be abolished without Congressional action. However, legislation (HR 3854) is pending to prohibit SSA from continuing the GRP should SSA fail to end the Project.

The GRP is a radical departure from current practice utilized in ALJ hearings. Normally, SSA ALJ hearings are structured to be nonadversarial. The presiding ALJ fulfills two roles: developing the record and making findings of fact and conclusions of law involving Social Security or SSI disability benefits (95% of ALJ workload). 20 C.F.R. §404.946, §404.952 (1985). This is in accord with the Supreme Court's recent statement that SSA has a duty to ensure that the "84-1923 fair and neutral procedure required by the statute and regulation" is provided to claimants who appeal benefit denials. See, Bowen v. City of New York No. 84-1923, June 2, 1986, unanimously affirming Heckler v. City of New York 742 F.2d 729 (2d. Cir. 1984). (The ABA filed a brief as amicus curiae on behalf of Social Security claimants in the Supreme Court in this case urging affirmance.)

The GRP alters this nonadversarial hearing structure. The Government Representative develops the case file to add information more "favorable" to the Social Security Administration. If the claimant is not represented, the Government Representative's role ends at that point. If the claimant is represented, whether by a skilled attorney or lay advocate, the government representative attends the hearing, may cross-examine witnesses and the claimant, and introduce evidence. 20 CFR §404.965 (1985). The ALJ hearing, then, becomes much more adversarial than the informal, factfinding hearing process that has traditionally existed.

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[1]The GRP is officially titled the Social Security Administration Representative Program (SSARP) 20 C.F.R. §404.965. Serious concerns about the GRP were raised by Symposium participants and others. These concerns can be summarized as follows:

(1) MORE EFFICIENT AND FAIR METHODS EXIST TO DEVELOP BETTER FACTUAL RECORDS FOR HEARINGS

If the purpose of the GRP is to ensure that a better factual record is developed upon which an ALJ can make a determination, it is unnecessary, and counterproductive to have this evidence gathered by a person whose role is to represent SSA against the claimant. Further factual development of claimants' records can and should be conducted by someone who is objective rather than in an adversarial relationship to claimants. The $1 million spent per year on the project could be used to improve initial determinations to minimize the number of appeals. Fact gathering by an SSA representative may

result in skewing the investigation against the claimant, ordering unnecessary medical tests, and delaying the process.

(2) THE GRP MAKES THE HEARING PROCESS MORE ADVERSARIAL

Social Security is a public agency charged with the duty to provide benefits to everyone who applies and meets stated eligibility requirements. In the GRP, Social Security staff persons represent the interest of the Social Security Administration as if SSA's interest is to protect Social Security funds from claims of eligible claimants. Symposium participants agreed that the ALJ hearing procedure should remain nonadversarial.

As one court recently noted:

> "Under the notice of proposed rule making and the final rule making by the Secretary in the adoption of the SSARP regulations, it was represented that the SSAR's would be non-adversary. It has become manifestly apparent to this court that the SSAR's in practice have been almost totally adversative, and that their pre-hearing development of claims has been one-sided development in favor of the Secretary in disregard of their duty to fairly and fully develop the claim not only for the Secretary but also for the claimant. This case just represents one bad example among dozens of others that the Court has observed since the inception of the program in October of 1982, at the Kingsport, Tennessee Office of Hearings and Appeals. The court cannot help but observe that if the experimental program cannot be fairly administered and if the SSAR's cannot act in a non-adversary manner in developing pending claims for hearing, the Secretary should consider abandoning this cumbersome, expensive and unfairly administered experimental program." Darnell v. Bowen, Civil Action No. 85-0021-B, W.D. Virginia, February 28, 1986

Attorneys attending the Symposium reported that Government Representatives recommend favorable decisions for claimants, only rarely - about 8% of the time - even when there is a slim chance that the claimant will lose on appeal. House Comm. Rept. No. 99-50 (1985) p. 28, 43. It is unseemly, at best, for representatives of the government to argue against granting benefits to clearly eligible claimants. Cf.

Testimony of Martin Wegbreit, House Comm. Report No. 99-504 (1985) pp. 47-51.

(3) THE GRP IS NOT AN "EXPERIMENT"

The GRP was originally justified as an "experiment." However, it is quite clear that the GRP was not designed to yield helpful data. No rigorous or formal study has been conducted and only minimal data has been gathered. Unfortunately, despite the fact that little data exists about or has been made public regarding the cost of the experiment (including the cost of additional consultative medical examinations requested by the Government Representative) or its impact on clients, the Social Security Administration continues to conduct the GRP. Four years of experimental data are certainly adequate to assess the utility and impact of the experiment. (House Comm. Rept. No. 99-504 (1985) We would not object to carefully controlled experimental changes in the appeals process conducted by the Social Security Administration (provided that adequate safeguards for the due process rights of claimants are present and opportunities for public notice and comment are provided). However, the GRP does not meet these standards. There is, therefore, no justification for continuing the GRP in its present form. Apparently neither efficient, fair, or justifiable as a continued experiment, it serves only to make Social Security hearings more adversarial, create the impression in the minds of the public that government agencies are not impartial, and further erodes the ability of old, weak, ill, and vulnerable individuals to receive a thorough and neutral consideration of their claim for benefits.

For all these reasons, the ABA should oppose continuation of this flawed "experiment."

B. The Appeals Council process should be further improved in certain respects and other basic issues should be studied.

The Symposium recommended specific reforms of the process utilized by the SSA Appeals Council to review ALJ decisions. Although the Symposium made recommendations with respect to the Appeals Council, we have offered two additional recommendations.

The Appeals Council is a 20 member adjudicative body created by the Social Security Administration to review decisions of Administrative Law Judges either on its "own motion" or upon a request from a claimant to determine whether they should become the final decisions of the Secretary of Health and Human Services, which can be reviewed by federal district courts. 20 C.F.R. §404.967 et. seq. (1985). The Appeals Council was not created by Congress, but by regulations of the Social Security Administration which delegate the Secretary's authority to render final agency decisions to this

body.

--The Appeals Council was sharply criticized by Symposium participants. While Social Security maintains that the Appeals Council may conduct a de novo review of findings of disability, the regulations for the Appeals Council do not appear to grant this power. 20 CFR §404.947(a)(1985). At the same time claimants' representatives note that Appeals Council review imposes extreme hardship on clients. Claimants whose benefits are approved at the ALJ stage may find their case being reviewed by the Appeals Council on its "own motion." At best, this results in long delays in starting to receive benefits. At worst, the Appeals Council sometimes overturns findings of credibility or other factual determinations made by an ALJ, for which there was substantial evidence, sometimes without reviewing the tape recording of the hearing. To have benefits reinstated, the claimant must appeal to federal district court.

On the other hand, the Council rarely agrees to review ALJ denials of benefits. The Council only agrees to review an ALJ denial when it finds an error in the ALJ decision. However, it often takes a long time for the council to decide to grant a claimant's request for review and the decision to grant a review may be based on only a superficial or cursory review of the record by one of the more than 350 paralegal "analysts" who assist Appeals Council members.

To address the problem of long delays, the Symposium recommended if the Appeals Council fails to reach a decision on a claim within a specified period of time, that the claimant be deemed to have exhausted his/her administrative remedies and may appeal directly to Court. In the proposed resolution, we have made this recommendation more specific so that no doubt remains about the recommendation and how it operates. We have specified that if the Appeals Council fails to render a final decision within 90 days from the time the Appeals Council review is requested, the claimant may proceed to federal district court.

Symposium participants also noted that some basic aspects of the function and role of the Appeals Council have not been adequately studied. Important unexamined issues include: whether the appropriate role of the Appeals Council is error correction, policy making, fact finding or precedent setting; the relationship between Appeals Council members and the staff who review ALJ hearing decisions and recommend Council action; and standards for determining which cases are appropriate for review by the Appeals Council. Despite the fact that over 100,000 cases are filed with the Appeals Council annually, the processes it utilizes have not been the subject of study and debate. While the Symposium identified serious issues, participants did not have time to adequately explore these issues and to do more than make simple recommendations. The issues enumerated above deserve serious study and analysis. We recommend that the Appeals Council be studied in

greater depth by organizations interested in improving the Social Security system.

CONCLUSION

The Social Security system affects millions of Americans each year. For many, decisions regarding eligibility for disability benefits will have profound effects on their well being. The processes used to make the difficult decisions regarding eligibility for benefits and the process claimants can utilize to appeal adverse decisions should, therefore, be fair and accurate. In fact, they should be the best that the American system of justice can provide. The ABA-sponsored Symposium on Federal Disability Benefit Programs provided an opportunity for experts with differing perspectives to offer recommendations for changes in this system to improve its functioning. Given the primary goal of the ABA -- to improve the American system of justice -- it is fitting for the ABA to participate actively in efforts to ensure that the Social Security Disability determination and appeals process is the best that this country can offer to its citizens. The resolutions submitted with this report should be adopted.

Respectfully submitted,

John H. Pickering, Chairman
Commission on Legal Problems of the Elderly

David B. Wexler, Chairman
Commission on the Mentally Disabled

August, 1986

Resolution of the
AMERICAN BAR ASSOCIATION
adopted by
The House of Delegates
February 1990

BE IT RESOLVED THAT the American Bar Association urges that federal legislation be enacted to provide that the Social Security Administration cease its policy of "nonacquiescence," and that such legislation incorporate the following principles:

A. Where two Circuit Courts of Appeals have decided the same issue of law adversely to the position of the Social Security Administration, regardless of whether another Circuit Court has ruled favorably, then the Secretary of Health and Human Services shall recommend to the Solicitor General of the United States that the last Circuit Court decision be appealed to the

United States Supreme Court, and, if the Solicitor General refuses to appeal or if certiorari is sought and denied by the United States Supreme Court, then that rule as enunciated by the two Circuit Courts ruling adversely shall be followed by the Social Security Administration in all jurisdictions;

B. Where a dispute arises as to whether an issue is the "same," a petition for mandamus also will lie in the second circuit issuing an adverse decision; and

C. Where mandamus is granted, imposition of liquidated damages up to $50,000 may be imposed as well as imposition of court costs, expert witness fees, and attorney fees.

Note: The purpose of this report is to provide background information. Only the resolution constitutes official ABA policy.

REPORT

The American Bar Association has condemned the practice of the Social Security Administration's refusal to follow Circuit Court decisions where the issue of law has been decided (ABA Recommendation #110, July 1985). The Social Security Administration has made few changes in its practices or its procedures, although it may tend to follow Circuit Court decisions more often in the same Circuit. The problems addressed by the American Bar Association continue to exist. The proffered resolution calls for enactment of guidelines which will result in a limit to the practice of the Social Security Administration in ignoring adverse Circuit Court decisions, establishes a procedure to force an appeal or acquiescence where diversity exists, and provides for uniformity.

The report to the House of Delegates, accompanying American Bar Association Recommendation #110 (adopted July, 1985), prepared by the ABA Standing Committee on Federal Judicial Improvements and the ABA Commission on Legal Problems of the Elderly considered the contemptuous policy of the Social Security Administration in failing to follow federal circuit court precedent in the past and called for legislative action to ensure that SSA henceforth adheres to the general legal principle that court precedents should be followed. The need for legislation to require SSA to follow precedent within the circuit is so clear it need not be reargued. Even if it is argued that SSA is following precedents today, this legislation is needed to assure that there is no return to past practices.

The proposal to force SSA to appeal adverse decisions and to seek uniformity among the circuits balances the needs of the government to contest adverse rulings by seeking a different result in another, as against the manifest unfairness of refusing to appeal cases once diversity is established or refusing to appeal after more than one loss. Effectively there are only eleven circuits where cases are likely to arise, and it is believed that if SSA loses in two circuits out of eleven that the issue in all jurisdictions. Individual claimants, frequently indigent, should not be forced to relitigate legal issues that SSA has lost but refuses to follow or appeal. If the Solicitor General decides an issue is not appealable after two circuit courts have ruled adversely, it seems only fair that the ruling be followed and that SSA seek a

legislative change if it continues to disagree with the adverse rulings rather than engage in the practice of intercircuit non-acquiescence.

Mandamus, where a dispute arises as to whether an issue is the "same," and the potential for the imposition of liquidated damages, court costs, and attorneys fees, are necessary because SSA has had a history of both blatant disregard of court opinions, and of so narrowly interpreting issues as to render the rule of law meaningless.

Last, it is believed that Congress will be receptive to regularizing an area where the failure to define limits to an agency's practice of intercircuit non-acquiescence has caused great hardship for large segments of the population.

Respectfully submitted,

David I. Harfeld
Chair

February, 1990

Chairman JACOBS. Ms. Sweeney.

STATEMENT OF EILEEN P. SWEENEY, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER

Ms. SWEENEY. Thank you.

Yesterday, I received a faxed copy of the testimony which Rudolph Patterson had originally planned to present today. Mr. Patterson is a private attorney in Macon, Ga., who has been representing people for a long time, since I was in eighth grade. I can assure each member of the subcommittee, that if you share Mr. Patterson's testimony with the finest private attorney or legal services attorney in your district, he or she will verify for you that all of the problems that he tells you about are happening to your constituents. These are problems that are occurring across the Nation.

I have Mr. Patterson's permission to mix his statement and my own. He identifies some outrageous practices of the DDS which assure delays. First, he states,

> We are constantly faced with the problem of the DDS issuing denial rationales which state that our claimants who have terminal illnesses can be cured with proper treatment within 12 months. It is just a constant source of irritation to the system of the United States and their doctors, to have nonexamining and, in many instances, nonpracticing physicians tell them that, with proper treatment, their cancer, their AIDS, their heart attacks, their strokes, their amputated limbs, their comas all will get well within 12 months, with proper treatment.

Second, the DDS in Georgia is refusing to adjudicate some cases until they impose a waiting period. Mr. Patterson provides four very compelling examples of current cases, one of whom is a

> 27-year-old female who had been hospitalized since December 1990, due to an automobile accident. She sustained multiple head injuries, a diagnosis of hydrocephalus, she is not aware of time and place, has minimal speech, and cannot move her extremities intentionally.

She is fed by a tube. Her case has been "medically deferred" until May 15, 1991. I am assuming that these "medical deferrals" do not get counted into the delays and "backlog" of "pending" figures that SSA is providing to the Congress.

Each of these examples is appalling. Each of these individuals should have been awarded benefits immediately. There should not be any question, they should have been granted. They probably are all having problems with their Medicaid and their hospital coverage at the same time due to SSA's delay. Mr. Patterson also reports that,

> Because of the delay that we are experiencing at the present time in the process, my office alone has experienced over 25 deaths of clients during the last 12 months, who were waiting for decisions.

That is something that I keep hearing. I am getting more and more calls from people all over the country whose clients are dying. It used to happen a little. It is a very bad problem in SSI, because no one receives the SSI if the person dies, unless there is a spouse or the person is the parent of a deceased child. SSA gets to keep all the money that they should have paid to the person. There is no back award paid to anybody, so they are rewarded, essentially, for delaying, particularly in cases of people with terminal illnesses. This just seems to be a quickly growing problem.

The reason that delays are so bad is that SSA does not have the staff to process cases at any level in a timely manner. It is very clear that the administration does not intend to ask for the funds needed. As Dr. Flemming and Representative Cardin both noted, this year's budget request assumes increases in the backlog.

Congress should create a few alternative ways to protect claimants and possibly at the same time motivate the administration to honestly state the amount of money it needs to properly run this program.

First, I agree with Dr. Flemming's statement that you really need to look at whether or not there is some way—and I think SSA already has the authority—to say that DDSs cannot be under State hiring freezes. There are States all over this country right now, including the State of Maryland, where they have eliminated positions in the DDSs, because the Governor wants to eliminate positions across the State government. These are fully federally funded positions. There should be no question about State hiring freezes.

SSA will tell you, probably not on the record, but they will tell you that even if you gave them all the money they could possibly want this year, the DDSs do not have the capacity to process the cases. They could not get up to speed, because of all the hiring limitations they are under, under the State governments.

The current law I think makes it clear that SSA could put in its contracts or regulations a requirement that States cannot have hiring freezes apply to these fully federally funded positions.

The second step is that the SSI program already has something called "presumptive disability," where a person who applies for benefits whose condition fits into certain categories can be automatically awarded benefits for 6 months, while SSA fully adjudicates the case. That provision should be expanded to the DI program. In addition, the list of categories of impairments which permit payment of presumptive benefits should be increased.

Third, SSA should be required to pay people if, after a certain amount of time, they have not been awarded benefits or have not received a decision in the case.

A couple of years ago, this subcommittee had a provision which Congress passed which requires that now, if the ALJ ruled favorably for the person, if the Appeals Council takes too long in reviewing the case, the person is automatically paid. Well, it is a miracle that very few are automatically paid. SSA gets those cases done in time, and they would do the same thing here. You would not have lots of people getting paid money. SSA would find a way to process the cases in time, if Congress required them to pay benefits.

Last, when Mr. Enoff was up here, he testified about the fact that SSA has incredibly high quality assurance accuracy levels for the DDSs right now and that this should assure Congress that all is well. That is exactly what SSA and I think even Mr. Enoff testified to in 1983, in 1982, and in 1984, when they were improperly cutting off 500,000 severely disabled people who Congress ultimately had to put back on the program. The accuracy rates mean nothing in terms of what is actually happening to real live people in this program.

Thank you.

[The prepared statement follows:]

NATIONAL SENIOR CITIZENS LAW CENTER
Suite 700
1815 H Street N.W.
Washington, D.C. 20006
Telephone (202) 887-5280

WASHINGTON D.C.
BURTON D. FRETZ
EXECUTIVE DIRECTOR
ALFRED J. CHAPLIN, JR.
TOBY S. EDELMAN
JOAN GOTTLICH
PATRICIA B. NEMORE
EILEEN P. SWEENEY
STAFF ATTORNEYS

LOS ANGELES, CA
NEAL S. DUDOVITZ
DEPUTY DIRECTOR
GILL DEFORD
JEANNE FINBERG
PETER S. KOMLOS-KROBSKY
SALLY HART WILSON
STAFF ATTORNEYS

TESTIMONY OF EILEEN P. SWEENEY, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, BEFORE THE SOCIAL SECURITY SUBCOMMITTEE, WAYS AND MEANS, MAY 2, 1991

Mr. Chairman, I appreciate this opportunity to testify today on the very serious problems which exist in the Social Security disability adjudication process. Many of the problems are structural and have been exacerbated by the cuts in DDS and local SSA office budgets and staffing over the last six years. These cuts have served to force increasing numbers of people with disabilities to seek justice from higher levels of appeal: the administrative law judges, the Appeals Council, the courts. And, unfortunately, far too many people with severe disabilities drop out of the process after being denied by the DDSs, never appealing to levels where they would most likely be found eligible. Other problems are the result of the very restrictive, illegal rules which SSA requires the DDSs to apply in adjudicating disability.

H.R. 1799 puts the emphasis right where it should be: at the front end of the process. Inclusion of face-to-face interviews with the decisionmaker at the first step and elimination of the reconsideration level of review will improve the quality of the process while also expediting the appeals process for those who still find it necessary to appeal. Specifically identifying the types of evidence required in the file before a decision can be made should help to assure that DDSs do their jobs properly. One additional area needs to be considered: having better procedures and better evidence, the decisions will still be flawed if SSA does not specifically, affirmatively order the DDSs to fully and fairly consider functional limitations. To get this message across, which is the opposite of the current message, SSA must aggressively and consistently use its quality assurance process to return inappropriate denials to the states.

There are a number of key problems with the work done at the DDSs, not all of which are their fault. The problems are:

1. **There is no face-to-face contact between the claimant and the decisionmaker.**

It is not realistic to expect that a person with a mental impairment or a person who is illiterate will fill out a form listing that limitation. First, s/he may not understand that s/he is so limited. Second, s/he may not wish to list it. A form listing back problems may in fact really be about serious mental impairments. If SSA and the DDS simply take the form as written, the person will be denied despite very severe impairments.

While a face-to-face contact with the individual will not identify all such cases, it can be very helpful in alerting the decisionmaker to explore for other problems, to seek a consultative examine to determine if a problem

exists. A face-to-face contact is also helpful in assessing the credibility of the individual's statements regarding pain and other symptoms.

2. No one in SSA or the DDSs is assisting claimants to complete the forms which provide information regarding their treating sources, the nature of their impairments, and their limitations.

The forms which a person is required to complete are very detailed. S/he must provide information about the names and addresses of physicians, hospitals, clinics; dates of treatment; nature of impairments; limitations on daily living activities. Despite this, a few years ago, under the leadership of the last Commissioner, SSA decided to call these forms "self-help" and has since been sending people home to complete them.

Not surprisingly, an SSA Atlanta Regional Study in 1987,[1] concluded that:

> "o *One-fifth of the claimants using self-help should have been excluded, using regional guidelines."*
>
> "o *Only one of every five [20%] claimants using self-help provided complete and descriptive information on the SSA-3368. These claimants had high school or college educations or work experience that involved writing or forms completion."*[2]
>
> ****
>
> "o *Two-thirds of the claimant completed SSA-3368's were not supplemented upon receipt in the FO [SSA field office]. Over half of these should have been, but were forwarded to the DDS with missing/incomplete/conflictive information..."*[3]

It is not too hard to figure out that assistance with these forms has been one of the casualties of the staffing cuts. It is critical that SSA local office staff be increased so that they can resume assisting people with these forms as well as many other requests which are now going unheeded.

As the Atlanta study reflected, the burden of the incomplete forms has fallen on the DDSs. Sometimes, they may call the claimant for more information, other times they go with what is on the form. Many people have been denied because the information on the forms, if they were ever returned, is so limited.

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1. A copy of this report appears in "Proposals to Improve the Quality of Services Provided by the Social Security Administration," Hearing before the Social Security Subcommittee, Ways and Means Committee, 100th Cong. 2d Sess. September 22, 1988 (Serial 100-86) at pages 100-130.

2. Id., page 101.

3. Id., page 105.

3. The DDSs do not see it as their obligation to collect all available evidence and to ask the right questions which would yield useful information from claimants, their families, and treating sources.

The list of evidence required in H.R. 1799 will be very helpful in assuring that the DDSs secure all of the needed evidence. However, two changes are needed. First, there should be an explicit requirement that the DDSs assist those claimants who cannot supply the information themselves to secure the evidence. It is the nature of many individual's impairments that they can not effectively secure the evidence required. Others are illiterate or poorly educated. While still others do not speak English. They need assistance not only in securing medical evidence but also in assuring that the range of evidence, particularly related to functioning, is in their file.

Second, it is critical that SSA secure reports on RFC and pain from treating sources as well as its own staff. SSA basically has two kinds of medical personnel related to the DDSs. The first are the medical staff in the DDS whose job it is to review files and make RFC determinations (however, see discussion below). These people review only the file. They never see the claimant. The second group are the consultative examiners who, for a fee, examine the claimant once, often for a very short period, and then write a report for the DDS. It is SSA's practice to avoid asking treating physicians or other sources, such as physical therapists or mental health counselors, for their opinions regarding the claimant's residual functional capacity. SSA does this so that it can avoid having any conflicting evidence in the record. Typically, this evidence is sought by advocates for the claimant. And, typically, it is accorded weight by the ALJ because the treating source is most knowledgeable of the person's limitations and has seen the claimant on a regular basis.

It is therefore very important that DDSs collect this information as well. It will go a long way to better informing the recommendations of their in-house physicians who must rely solely on the paper in the file. Improving the quality of the paper in the file should improve the quality of the decision made on that evidence.

4. The DDSs do not purchase consultative examinations for poor people who medical files are thin due to the lack of health care coverage.

a. Having been at one extreme in purchasing too many CEs, the DDSs have now hit the other extreme, failing to purchase CEs for those who need the evidence to establish disability.

Unfortunately, not every one has a treating physician who can write reports from the vantage point of a long-standing relationship with the claimant. This is particularly true for people who are poor and disabled who do not have access to health care coverage. It is often the case that a person who knows that s/he is disabled may not be able to articulate the full extent of his/her medical problems. And, s/he may not have been seen by a physician for some or all of the problems.

These are the people who most need to be seen by consultative examiners. In the early 1980's, SSA sent almost everyone to consultative examiners, often to "volume providers." The quality of the exams and the reports was shoddy; the reports were used to deny or terminate benefits; and the Congress became concerned. There were hearings in

this Subcommittee[4] as well as others.[5] SSA has slowly moved away from the practice of excessive use of CEs.

The problem is that now it has gone too far in the other direction. Probably for budgetary reasons, it is now very difficult for poor people who need the consultative examination to establish eligibility to get the DDS to send the person to a CE. Attached to this statement is a copy of a notice which the California DDS recently (March, 1991) sent to a claimant. It states, in part:

> *"In order to evaluate your disability claim, it is necessary to have medical information about your alleged impairment(s). It is also necessary that this information be current enough to reflect your present condition. We not that you have not recently been seen by a physician regarding your alleged impairment(s). Before we can take further action on your claim, we need medical evidence which establishes the existence of a medically determinable impairment. It is your responsibility to provide this."*
>
> *"Please take the enclosed medical form...to a physician of your choice and have him complete it regarding your current condition. YOU ARE RESPONSIBLE FOR CHARGES FOR THE MEDICAL EXAMINATION. We will only pay for the preparation of the report. Enclosed is a return envelope for the convenience of the doctor...."*
>
> *"...If you have any problems with this, you may call us collect, station-to-station."*

Nowhere in this letter does it say that, if you do not have a doctor, SSA can send you to one of theirs. Nor does it say, despite a 1984 change in the law, that SSA will use the treating physician as a consultative examiner (and therefore pay the physician).

These practices need to be reversed. It is critical that SSA assist those who are financially unable to establish their medical eligibility for either Social Security or SSI disability.

b. **The Office of Hearings and Appeals should have its own budget for purchasing CEs, the funds should not be taken from DDS budgets.**

What happens to the poor person who does not get the needed CE referral from the DDS? Some are denied and do not appeal. They go without benefits to which they are legally entitled and which they desperately need. Others who are denied seek representation. Their representatives file the appeal to the ALJ level and are sometimes able to persuade the ALJ to order a consultative examination. Then, based on the CE's report, the ALJ often awards benefits. The irony is that the CE ordered by the ALJ is paid for from the state

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4. See "Possible Irregularities in Medical Examinations Purchased from 'Volume Providers' for the Social Security Disability Program," Hearing before the Subcommittee on Social Security and the Subcommittee on Oversight, Ways and Means Committee, 97th Cong. 2d Sess. March 11, 1982 (Serial 97-55).

5. See, for example, "Social Security Disability Insurance and Supplemental Security Income Programs," Hearing before the Intergovernmental Relations and Human Resources Subcommittee, Government Operations Committee, 99th Cong. 1st Sess. December 11, 1985.

DDS's budget. So, the claimant waited unnecessarily, often another year, for a CE exam and benefits because the DDS was trying to save money and the DDS ended up paying for the CE anyway.

There are a couple problems here. First, I have heard of states whose ability to order CEs was seriously affected by the requirement that they cover the cost of ALJs' CE orders. It would make sense to require that the Office of Hearings and Appeals at SSA have its own budget for CEs. The DDS budgets are already very tight. They should not be expected to set aside funds for CEs ordered by ALJs. This could result in DDSs once again ordering CEs in cases when they are needed in cases pending before the DDSs.

5. The DDSs are not permitted by SSA to fully consider the residual functional capacity of the claimant.

a. DDSs make formulistic assessments of RFC, they do not consider each person's limitations.

All the process improvements in the world are not going to correct the fact that SSA does not permit the DDSs to fully consider functional limitations. Under H.R. 1799, the DDSs will collect all the evidence, but they will not necessarily use it to make higher quality decisions. SSA very effectively uses its "quality assurance" process to limit DDS allowances to cases which meet the listing of impairments. Very few DDS allowances are made based on the steps in the sequential evaluation process which are based upon functional limitations and vocational factors.

Over the years, including very recently, there have been repeated examples of DDSs relying upon secret manuals, lists, and memory of the contents of these manuals, as the bases for denying benefits. Typically, the manuals provide a formulistic approach to disability assessment, ignoring the actual facts in the individual's case. For example, a person with lower back problems will always be determined to have the residual functional capacity to perform "light work." This generally results in a denial of benefits. This assessment is made despite evidence in the file that the person can hardly lift a gallon of milk, or can only sit and stand intermittently for short periods of time, or, due to heavy doses of pain medication, is perpetually drowsy.

SSA periodically issues some hortatory language in a circular telling DDSs not to do this. However, DDSs are not fools. They know those memos are not for them. They know they are supposed to pay attention to the return memos received through the quality assurance process. Until SSA affirmatively changes its QA process to require consideration of all evidence in the file in making RFC assessments, it is difficult to see that much will change.

b. DDS physicians do not make the RFC determination in most cases, although they sign them. They do not review the files in the vast majority of cases before signing the RFC form. And, even when they make an RFC determination, they are limited in the determinations they can make.

The result of budget cuts has been that DDS physicians rarely actually review a file before they sign the form which identifies the person's RFC. SSA is paying for physicians to give the appearance that a real medical assessment has occurred. SSA pays a lot of money for what could just as easily, and just as fraudulently, be accomplished with a rubber stamp.

The most recent public manifestation of this ongoing problem is a case which was filed in West Virginia recently,

Boring v. Sullivan, Civil Action No. 2:91-0429 (S.D.W.Va.). The following two paragraphs of the complaint spell out just how unfair the process is:

> *"34. Subsequent to October, 1989, it has been the policy and practice of the defendants to have physicians make residual functional capacity determinations in only those cases determined by a lay disability examiner to be complex. In all other cases, physicians transpose already completed residual functional capacity assessments from color-coded paper onto the assessment forms and then sign these forms and the disability determination transmittal forms, without actually making the residual functional capacity determinations themselves or reviewing the medical evidence in the case file."*
>
> *"35. Defendant's policy and practice of denying claims based on residual functional capacity evaluations which were not made or reviewed by physicians was secret. In fact, defendants developed a color-coded system to avoid detection of this illegal practice."*

There is formidable evidence to establish the claims made in the complaint. This practice, which takes various forms in different states, has to be stopped. The statute already requires that a psychiatrist or psychologist perform the RFC for individuals with mental impairments. 42 U.S.C. §421(h).[6] And, SSA's own regulations require that a physician "complete" the RFC forms for all claimants. 20 C.F.R. §404.1546.[7] SSA must be required to take seriously its obligation to fully consider all functional limitations and its obligations to have physicians thoroughly review the files.

c. SSA's quality assurance process makes no effort to improve the situation; in fact, it affirmatively encourages

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6. 42 U.S.C. §421(h) provides:

"(h) Evaluation of mental impairments by qualified medical professionals."

"An initial determination under subsection (a), (c), (g), or (j) of this section that an individual is not under a disability, in any case where there is evidence which indicates the existence of a mental impairment, shall be made only if the Secretary has made every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment."

7. 20 C.F.R. §404.1546 provides:

"Responsibility for assessing and determining residual functional capacity."

"The State agency staff medical or psychologicall consultants or other medical or psychological consultants designated by the Secretary are responsible for assuring that the agency makes a decision about your residual functional capacity. In cases where the State agency makes the disability determination, a State agency staff medical or psychological consultant must assess residual functional capacity where it is required. This assessment is based on all of the medical evidence we have, including any other assessments that may have been provided by treating or examining physicians, consultative physicians, or any other medical or psychological consultant designated by the Secretary..."

current practices; thus, states are rewarded for their shabby, unfair treatment of claimants.

As discussed in in 5(a), above, without clear directives from SSA's quality assurance component that DDS physicians must (1) review the complete file and (2) make a complete and fair original assessment of RFC, and without (3) money from SSA for the DDSs to hire sufficient numbers of physicians, changing the procedures will not alone solve the problems.

The importance of the quality assurance process can not be understated. In hearings before the Senate Aging Committee in 1983,[8] the General Accounting Office reported on the results of its investigation into how DDSs learned about the policies for adjudicating the claims of people with mental impairments. GAO stated:

> *"How the [mental impairment] criteria are applied by SSA is of fundamental importance because cases are evaluated by SSA's quality assurance system, and State agencies look to case returns from SSA's regional disability assessment branches (DAB's) as the clearest indicator of SSA's intent....Several examiners told us it only takes a few returns before you change the way you evaluate evidence."* (Hearing, page 15)

6. Proposals to cut the delays.

a. **States should be barred, as a condition of their contracts with SSA, from imposing any state hiring freezes or other limitations on positions which are totally funded by SSA.**

Hiring freezes at the state level as well as efforts by states to eliminate positions across their governments are having a very severe impact on SSA's ability to increase the staffing in the DDSs. It is SSA's fault that they are so low, due to irrational budget cutting over the past few years under the last Commissioner.' However, now that there is a chance to restore some staffing there, it is my understanding that SSA does not believe that DDSs have the capacity to expand as much as is needed. SSA staff are saying, quietly, and the President's budget documents reflect this, that we can expect the backlogs and delays to continue to grow. This is totally unacceptable. There is no reason why claimants should have to wait many months or years for the benefits to which they are legally entitled.

SSA should be barring states from applying such hiring freezes in the DDS programs. While I think the current statutory language[9] is broad enough to permit SSA to impose

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8. "Social Security Reviews of the Mentally Disabled," Hearings before the Special Committee on Aging, U.S. Senate, 98th Cong., 1st Sess., April 7 and 8, 1983. [S. Hrg. 98-170].

9. 42 U.S.C. §421(a)(2) provides, in part,

"...[T]he Secretary shall promulgate regulations specifying, in such detail as he deems appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function in order to assure effective and uniform administration of the disability insurance program throughout the United States. The regulations may, for example, specify matter such as---

such a prohibition, if SSA does not agree then the Congress should act immediately to require that this be a condition of all contracts entered into with the states under 42 U.S.C. §421(a).

b. Presumptive disability categories should be expanded in SSI and created in DI.

In SSI, claimants with certain categories of impairments are entitled to receive six months of benefits while they await SSA's full determination of their disability claim. 10 The receipt of "presumptive disability" benefits makes the waiting period somewhat easier, so long as the final determination awarding benefits occurs within those six months.

Presumptive disability does not exist at all in the Social Security disability program. Extending presumptive disability to the DI program and also expanding the categories of impairments covered in both programs would help address some of the effects of the delays for at least some individuals.

c. Claimants should be paid their benefits if SSA is not able to act on their claims within reasonable time frames.

The bottom line is that SSA needs a great deal more money to increase staff in order to process claims more quickly at all levels. The Administration does not seem to be capable of asking for the money it needs. Therefore, until such time as the Administration honestly asks for the funds needed to process all cases in a fair and timely manner, Congress should require that SSA pay benefits to individuals who have filed disability applications (in DI or SSI or both) as soon as their cases have been pending at any level for more than a set period of time.

The effects of lack of income on people with disabilities are profound. They lose their homes, whether mortgaged or rented, they have no health coverage, and their medical conditions deteriorate. As a result, the time frames should be short, no more than 60 days at each step of the process, possibly 90 days at the ALJ stage.

Creation of advisory panels at the DDS level would be very useful.

The notice for this hearing asks about the value of requiring DDSs to have advisory panels. In the states where such panels have existed, such as Massachusetts and Pennsylvania, the panels have served many useful functions. They have provided a means of communication between the DDSs and the advocates and people with disabilities in the states, often eliminating problems which previously would have led to litigation. They have also been able to establish special coordinated programs which assist people with disabilities in that state. For example, in Massachusetts, the DDS has been involved in outreach to people who are homeless. They have also had special rules for processing the cases of people with AIDS. Panel members have also been able to assist the states in identifying medical specialists who will work with them.

"(A) the administrative structure and the relationship between various units of the State agency responsible for disability determinations,..."

10. 42 U.S.C. §1383(a)(4)(B). The list of impairments considered to be presumptively disabling is set forth at 20 C.F.R. §416.934.

Based on the experiences of states which have had such panels, Congress should require that each DDS establish a panel. It will be important that there be a requirement that the panel include advocates who represent people in Social Security and SSI cases as well as individuals who are current or former beneficiaries.

There is no need for a Social Security Court; creation of such a court will severely disadvantage people with disabilities and will undermine their ability to secure fair decisions based upon the law.

While there is a great deal of merit to proposals to eliminate Appeals Council, the Social Security Court is not the solution to the problems facing the administrative process. H.R. 1799 correctly focuses on the part of the process where change is needed: the first steps. The number of cases in the courts will be reduced substantially if the first steps in the process are fair and if the Secretary would affirmatively act to eliminate all vestiges of his policy of non-acquiescing in Circuit Court precedent. To deprive the average American of access to the generalist, local federal district courts of this country would be to drastically cut back on the appellate rights of people with disabilities.[11] The need for review before the district courts was obvious in the early 1980s for beneficiaries and has not diminished for applicants since that time. The American public understands the key roles which both the courts and the Congress served in reversing the very serious problems in the early 1980's. They would, very correctly, view such as change as a significant cut in the protections available to the average person.

The problems are up front in the process. Reforms should address those problems.

Thank you for this opportunity to testify.

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11. There are also many more specific problems which would result from the creation of such a court. These include: (1) Access for individuals with disabilities and their attorneys will be severely limited. Instead of district courts throughout the country there would be a panel of less than 20 judges to hear these cases, based probably in Washington, D.C. (2) Proposals to create a specialized court limit the types of issues which can be appealed to a higher court from the specialized court; currently, no such limits exist. (3) The Federal Rules of Civil Procedure would not apply. It is also not clear that the court would have injunctive powers. It would be impossible to secure the scope of relief provided by courts over the past two decades to classes of individuals in actions against SSA's illegal policies and practices. (4) Some proposals contemplate that the costs of the new court would be covered by the Social Security Trust Fund, unnecessarily and inappropriately shifting the cost of judicial review out of general revenues. (5) It is not clear that there would be an opportunity for a hearing before such a court.

NRR/13

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

DEPARTMENT OF SOCIAL SERVICES — DIVISION OF DISABILITY EVALUATION

☐ P.O. Box 81326
San Diego, CA 92138

☐ P.O. Box 3819, Terminal Annex
Los Angeles, CA 90051

☐ P.O. Box 1827
Sacramento, CA 95809

☐ P.O. Box 60999, Terminal Annex
Los Angeles, CA 90060

☐ P.O. Box 24225
Oakland, CA 94623

☒ P.O. Box 1072
Fresno, CA 93716

March 21, 1991

CA SSN:

Your claim for Social Security disability benefits under the Social Security Act has been sent to this office for medical development and evaluation.

In order to evaluate your disability claim, it is necessary to have medical information about your alleged impairment(s). It is also necessary that this information be current enough to reflect your present condition. We note that you have not recently been seen by a physician regarding your alleged impairment(s). Before we can take further action on your claim, we need medical evidence which establishes the existence of a medically determinable impairment. It is your responsibility to provide this.

Fresno MSS/TEMP

Please take the enclosed medical form (SSA-0000-0000) to a physician of your choice and have him complete it regarding your current condition. YOU ARE RESPONSIBLE FOR CHARGES FOR THE MEDICAL EXAMINATION. We will only pay for the preparation of the report. Enclosed is a return envelope for the convenience of the doctor.

Please fill out the appointment form below, and return it to this office as soon as possible. Your prompt action will prevent further delay of your claim.

If you have any problems with this, you may call us collect, station-to-station.

Very truly yours,

N. Riley,
Disability Evaluation Analyst
Telephone (209) 297-3662

Enclosures

Chairman JACOBS. Thank you, Ms. Sweeney.

Mr. Bunning.

Mr. BUNNING. No questions.

Chairman JACOBS. Mr. Crane.

Mr. CRANE. No questions.

Chairman JACOBS. We appreciate very much the contribution of the witnesses on this panel. Mr. Pickering, you gave us some ideas about possible amendments to the legislation, for which we are grateful.

Mr. Breger, you mentioned the nature of the face-to-face proceeding in the initial process, and Elaine Fultz, our staff member who has prepared this hearing, has a comment as to the reasons for the evidentiary nature in the bill.

Ms. FULTZ. Mr. Breger, you said in your testimony that you were not sure why we used that word and perhaps we had in mind something approximating an ALJ hearing. I would like to explain for the record that we used that word for two reasons.

First of all, that is the same word that appeared in the 1984 amendments, which this subcommittee approved when Mr. Pickle was chairman, that required a face-to-face meeting between a beneficiary and the agency, if benefits are terminated after CDR and the person appeals to the reconsideration level. So we were simply borrowing that same language.

Second, if you look at the 1984 amendments, they suggest that that language means that the claimant must be informed before the hearing of his right to submit evidence at the hearing and his right to representation. That is why we used those words.

Mr. BREGER. Having taught for some years at the University of Texas Law School at Austin, I know that whatever Congressman Pickle wants is always a good thing. [Laughter.]

Chairman JACOBS. Or you would be in one yourself.

Mr. BREGER. I merely was suggesting that you might want to consider the language that might underscore the informal nature of that interaction, because at least it is not then self-evident that the term "evidentiary hearing" is a term of art.

Chairman JACOBS. I think that both purposes probably could be achieved.

Mr. Pickering.

Mr. PICKERING. With the Chair's permission, I would like to add another testimonial for Mr. Cardin, who unfortunately had to leave. The American Bar Association gave him one of its highest awards a couple of years ago, the Pro Bono Award for the work that he has done in the legal aid field.

Chairman JACOBS. I assume that award had no cash prize.

Mr. PICKERING. No cash prize. It was a very nice plaque.

Chairman JACOBS. Thank you very much. Dr. Flemming. It is always an honor to have you here, and the rest of you. Thank you all very much.

The next panel is the National Council of Disability Determination Directors, Stan Kress; National Association of Disability Examiners, Tom Christopher; American Federation of Government Employees, John Gage; and the National Treasury Employees Union, Stewart Goldstein.

Mr. Kress, you are the lead person.

STATEMENT OF STAN KRESS, PRESIDENT, NATIONAL COUNCIL OF DISABILITY DETERMINATIONS DIRECTORS

Mr. KRESS. Mr. Chairman and members of the committee, I am Stan Kress, and I appreciate the opportunity to testify, and I will do the best I can to slash and cut in every possible spot, if you will put my full testimony in the record, and thus try to curry your favor.

Chairman JACOBS. We will gladly do that, yes.

Mr. KRESS. I would just like to point out that, over the past number of years that the DDSs and the ALJs have jointly been making decisions on disability, the allowance rate at the DDS level has risen and fallen, depending on the adjudicative climate that has been in process at the time.

In the middle 1970s, it was higher, it fell during the early 1980s, and has risen again recently.

Very often, we find that the administrative law judges have followed that same rotation, with their allowance rates raising and lowering and raising again. They have, in effect, really mirrored us, only in a less conservative fashion. We think that there are a number of reasons for that, some of the main ones being the substantive evidence rule that is used by the ALJs. We are not allowed to use that kind of a process at the disability determinations services at the State level. In addition to that, they are able to use court precedence and other kinds of rules that we are not allowed to use, as was testified earlier.

Finally, an additional key difference is that we do not have that face-to-face contact between the decisionmaker and the claimant. As a matter of fact, our group surveyed all of the States last week and asked them about face-to-face initiatives, and at that point everyone of them, 100 percent of those that responded said that they felt that face-to-face contact with claimants would improve the accuracy of decisions.

As a matter of fact, two-thirds favored a face-to-face predenial interview or an evidentiary hearing at reconsideration. There was some split amongst the group as to how that should best occur. There was, however, total agreement that more resources are going to be needed, if we implement this kind of a process.

We would like to suggest that we do need a little additional time in order to study the different models and determine which one is really the best and then get on with implementing one, within a reasonable period of time.

We would suggest that, in addition to some of these problems, that we have also had considerable problems getting decisions made as quickly as we should have done. As a matter of fact, some of my written testimony has been quoted here earlier suggesting that we are going to go from 486,000 cases pending at the beginning of the fiscal year to nearly 800,000 cases pending by the end of this year. A major cause of that situation lays at the doorstep of OMB, who refused to release the contingency funds at the time when they were really needed. However, we are thankful for what has now been released.

We suggest that in may States it is going to take 1 to 3 years to dig out of this particular hole that we have gotten ourselves into,

because of the rising pending caseloads. We suggest that whatever budget we are given for fiscal year 1992, that we be given it as early as possible in the beginning of the fiscal year, so that we can begin to make progress with these backlogs.

I would like to briefly talk about the insularity issue and say that the only example that we can find that we think is critical in the insularity area is the failure for us to have face-to-face contact with the claimant. Other than that, we think we work very well with other State agencies, advocates, and with the Federal Government, in order to make sure that we are kept abreast of their concerns and have a good working relationship with them. We suggest that if we are going to have an advisory group, that it be at the national level, where policy is made. This is really the place for the advisory group. There they could put pressure on SSA for the changes in policy that might be necessary.

I have not even got the yellow light yet, and I am going to quit, Mr. Chairman. Thank you very much.

[The prepared statement follows:]

STATEMENT OF STAN KRESS, PRESIDENT
NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

Mr. Chairman, Members of the Committee, I appreciate the opportunity to testify on behalf of the National Council of Disability Determination Directors (NCDDD) concerning the state operated Disability Determination process of the Social Security Administration (SSA). We will also testify concerning the appeals process, the accuracy of the decisions and give suggestions on improving the process.

With your permission, we would like to start by presenting several facts. During the late 1970s, the Disability Determination Services (DDSs) were allowing over 40% of the initial claims and approximately 18% of the reconsideration claims, while the Administrative Law Judges (ALJs) made favorable decisions on approximately 55% of the claims on which they held hearings. During the 1981 through 1983 period the allowance rates of the DDSs fell to approximately 30% on initial applications and 13% at reconsideration. The ALJ favorable decision rate for that period also dropped to approximately 52%. During the years since 1984 the allowance rate of the DDSs has risen to 39.1% at the initial level and 16.7% at reconsideration in FY 1990. In spite of these increases in DDS allowance rates, the ALJ favorable decision rate has also risen to over 62%.

DDSs often call these variances in the allowance rates the "adjudicative climate". During the '70s, the climate was favorable for allowing benefits. During the early '80s there was concern about the impact on the trust funds, of continuing to pay beneficiaries who were no longer considered disabled, therefore, we were ceasing the benefits of many beneficiaries as well as allowing fewer claimants at the initial level. Due to a number of successful court cases and changes in the law, the pendulum has started to swing the other direction again. During these changes in the adjudicative climate, the ALJs have not monitored our actions but have mirrored them. When we acted in a more conservative fashion, so did the ALJs. Since we have become less conservative, so have the ALJs.

I believe we should correct the impression that the ALJs are actually allowing the same case that the DDSs denied. With the passage of time (six months to a year) some impairments worsen. New impairments that were not even known to the DDS sometimes develop. New evidence becomes available and is introduced. The ALJs may be less limited than the DDSs when purchasing medical and vocational evidence. Often, the ALJ is reviewing an entirely different case than the one seen by the DDS. Any or all of these factors can cause a reversal. However, the two most critical factors are:

1. The "substantive evidence" rule used by the ALJs to make their decisions may create an entirely different decisional environment than one the DDSs operate in. ALJs must conform only to the law and to the regulations while the DDSs must also conform to the POMS and are guided by numerous SSA reviews. If both the DDSs and the ALJs followed a uniform application of law and regulations and had equal reviews done on the quality of their work, the reversal rate would significantly decrease.

2. Face-to-face contact with a decision-maker makes a difference. The absence of direct claimant contact at the state DDS level must be considered a contributing factor in creating the difference in the two decisions.

The NCDDD surveyed the state DDS Directors last week and found that (of the 40 states who responded) they universally felt that face-to-face contact with claimants would improve the disability decision-making process and the accuracy of disability decisions. There was some debate about how that contact should take place. Two-thirds favored a face-to-face pre-denial interview or an evidentiary hearing at reconsideration. They were evenly split as to whether it would be best

to conduct an interview prior to an initial denial or conduct an evidentiary hearing in place of the reconsideration level of appeal. The other one-third favored an interview with the claimant at the beginning of the application for disability benefits.

There was total agreement however, that if face-to-face is introduced into the process additional resources will be needed. Most felt that if resources were too limited to do full-scale hearings, that an interview in the SSA field office with a specially trained Disability Specialist or a telephone interview with a DDS examiner would still help "somewhat". The first choice, however, and the one deemed most effective, would be for the DDS decision-maker to have a face-to-face pre-denial interview or an evidentiary hearing at reconsideration with the claimant. Since there is some debate amongst the DDS professionals as to which method is best, the prudent course at this juncture would be to have SSA proceed with their pilots and determine the best and most cost effective method to implement.

These two factors, having the DDSs and the ALJs use the same standards and providing face-to-face contact with claimants early in the process would undoubtedly improve the "accuracy" of decisions and decrease the ALJ reversal rate. Implementation of these changes, in addition to requiring the ALJs to remand all cases presenting new impairments to the DDS, could also improve the timeliness of the decisions. Another key factor in improving the timeliness of DDS decisions relates to having adequate resources and adequate staff to adjudicate the claims. A strong majority of the DDSs say they now have sufficient funds to complete this fiscal year. However, while we waited six months for OMB to release the contingency funds the pending caseloads in the country rose from 486,000 to 578,000. With the receipt of the early Zebley cases and the need to process 80,000 CDRs, the pending cases will likely rise to 820,000 by September 30. In other words, it's going to get worse before it gets better.

With the delay in acquiring the contingency funds and the Zebley cases arriving at the same time as the Zebley funding, there simply was not enough lead time. As I testified in February, it takes six to nine months to hire and train examiners, once the funds are authorized. Most states are now in the process of hiring and will soon start training. If FY '92 funds are adequate and if they are released at the beginning of the fiscal year, the timeliness of decisions should begin to improve. However, even if adequate staffing is provided, in some States where the backlogs became overwhelming, it will take 1-3 years to regain effective control of their work and provide top quality, timely service. In that vein, most states feel that a DDS administrative budget of $868 million is at least 6% below what is really needed for the non-Zebley part of the disability workloads for FY '92. If face-to-face procedures are implemented on a large scale, this amount will need to be increased by an appropriate amount.

Another way that service and timeliness can be improved is by fully implementing nationwide the automation or electronic data processing (EDP) systems that are available. Many states are still operating without these advantages and combined with reduced staffs, timeliness suffers.

Finally, we would like to speak to the issue of "the insularity of the DDSs". The only example of insularity that we can identify is the lack of face-to-face contact with claimants. We agree that solving this problem should be a priority. However, with as much significant and sustained communications between DDSs, Regional Offices, and the Central Office of SSA as there is, the "insularity" of the DDSs is certainly arguable. In addition, most DDSs have developed excellent working relationships with such sister state agencies as the Department of Mental Health, Mental Retardation, Vocational Rehabilitation, Substance Abuse Services, Medicaid, Social Services, Crippled Children's Societies, protection and advocacy agencies, Legal Aid, AIDS task forces, homeless teams and a variety of others social and medical agencies. The effect of these strong working relationships is increased understanding of adjudicative policies and procedures as well as improved referral patterns. These relationships benefit people with disabilities.

Medical and legal experts, as well as advocates, are already involved at the national level in the design of our program. To have local experts "advising" individual DDSs seems to be incongruent with the expectation that we administer a national program. While DDSs interact with local advocates and seek to serve the disabled public in whatever ways we can, that activity is quite different from the perceived intent of this question. We believe that whatever value "DDS advisory groups" (as described in this context) have would be more relevant at the national, rather than the state level.

As before, we appreciate the opportunity to present testimony before this distinguished subcommittee and look forward to doing so again in the future.

Thank You.

Tab A

NATIONAL COUNCIL OF DISABILITY DETERMINATION DIRECTORS

QUESTIONNAIRE

(Please return to Stan Kress no later than 04/26/91)

40 STATES RESPONDED

In an earlier survey, 63.5% of you stated you thought that the inclusion of a face-to-face interview or hearing would improve the disability decision. Please review the enclosed face-to-face models (Tab B) and answer the following questions. Assume that adequate resources would be made available (that money and staffing is not a deterrent):

1. Would one or more of the models improve the disability decision-making process?

   Yes __40__ No __0__

2. Of the six models, 1-3 at intake and 4-6 at the end of the line (2 with interviews prior to the initial denial and 1 a hearing at recon) which would most improve the disability decision-making process? (Please choose one regardless of your answer to Question #1)

   (1) _11_ (2) __1_ (3) __1_ (4) _12_ (5) __2__ (6) _13_

3. If somewhat more limited resources were available, which option(s) would still improve the decision-making somewhat? (Choose one or more)

   (1) _18_ (2) _2_ (3) _10_ (4) __2__ (5) __1__ (6) __8__

4. What, if any, are your major concerns with the models?

   #1 Comment:

   Adequate resources must accompany and be appropriate to handle these or other program enhancements!

Prior to answering Questions 5-11, please review your revised DDS Annual Planning and Funding Authorizations, dated March 29, 1991 (Memo DI-17-10)

5. Will the staffing suggested be adequate for FY 1991? (Zebley workloads and staffing are not to be included)

   Yes __29__ No __8__

6. Will the funding be adequate? (Not counting Zebley)

Yes 32 No 6

7. Will your DDS be able to clear the total workload planned for?

Yes 20 No 18

(If you answered "Yes" go to Question #10)

8. If no, what percent of that workload do you expect to clear?

of No's: 90 % average

9. If no, why won't you be able to do so?

Lack of Lead Time 18
Lack of Staff 4
Lack of Funds

Other (List) 3

10. Will you be able to clear your budgeted CDR workload?

Yes 20 No 18

(If you answered "Yes" go to Question #12)

11. If no, what percent of the CDR workload do you expect to clear?

of No's: 41 % average

12. Do you feel a National DDS budget of $868 million, not counting Zebley, is adequate for FY 1992?

Yes 12 No 20

(If you answered "Yes" go to Question #14)

13. If no, by what percent is it too low?

3% 6% 11 9% 3 12% 3 More than 12%

14. What else could SSA do to help your DDS meet budgeted disposition expectations? (Do not include what should have been done/ that's water under the bridge, or what has now been done/ funding and staffing allocations)

THANK YOU!

Tab B

FACE-TO-FACE MODELS

I. Claims Intake - 3 variations

1. Field Office (FO) Disability Specialist

   * An SSA employee who would receive disability program training similar to that provided to a DDS examiner

   * The specialist would conduct the disability interview

2. Outstationing DDS Employees in SSA FOs

   * The employee could be assigned permanently to an FO or employees could rotate daily or over some other period (would allow the claims intake interviewer also to be the decision-maker).

3. DDS Employees Take Telephone Interviews

   * The DDS employee would be located in the DDS and would take the disability interview over the telephone.

   * Also would allow the interviewer to be the decision-maker.

   * FO would continue to conduct the interview with special needs groups (e.g., homeless and deaf claimants).

II. Decision Process - 3 models

4. Face-to-Face Interview Before Denial

   * Current procedures would apply up to point where an unfavorable determination is warranted.

   * DDS would release a personalized predenial notice stating:

     -- what evidence is in file
     -- what it shows
     -- why claimant would be found ineligible

* The notice also would offer a face-to-face interview before formal denial is issued

* If claimant declines, or when the formal denial is issued, claimant would have appeal rights to the administrative law judge (ALJ)

* Model also would feature encouraging ALJ offices to make more aggressive use of their current remand authority.

5. Face-to-Face Interview Before Denial - Mandatory Remand

* Same as Model 4, except ALJ would be required to remand the claim to the DDS to evaluate any new evidence.

6. Disability Hearing at Reconsideration

* A face-to-face hearing would replace the paper reconsideration process.

* PDN would inform claimant that next appellate step is a face-to-face reconsideration hearing with the DDS decision-maker.

* If claimant is unable to appear or waiver the right, a paper reconsideration would be conducted.

* A variation is that a Federal disability specialist (DS) would conduct a hearing

  -- If so, Process would be similar to the current DDS prehearings units and DHUs that is:

  -- DDS would review claim, develop for any additional medical evidence and attempt to issue a favorable determination.

  -- If it can't, the DS would conduct a hearing.

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Tab C

	DDS Allowance Rates (SSI & SSDI Combined) Initial	Recon	ALJ Receipts	ALJ Favorable Decisions
1973	43.9	N/A	72,000	46.0%
1974	40.6	N/A	121,000	41.6
1975	38.5	N/A	155,000	41.9
1976	36.3	N/A	158,000	42.7
1977	49.6	23.1	193,000	47.0
1978	41.3	18.8	196,000	49.3
1979	36.2	16.5	226,000	53.0
1980	32.6	14.6	252,000	55.8
1981	30.1	12.7	281,000	55.2
1982	28.8	11.4	321,000	52.7
1983	31.6	14.2	364,000	52.7
1984	34.8	15.6	272,000	51.6
1985	36.2	14.3	245,000	50.9
1986	39.3	17.0	230,000	48.3
1987	36.4	14.6	278,000	54.0
1988	35.6	13.8	290,000	56.2
1989	36.7	15.3	302,000	59.3
1990	39.1	16.7	310,000	62.4

Chairman JACOBS. You curry inestimable favor with the committee. [Laughter.]

Mr. Gage, I like you, too.

STATEMENT OF JOHN GAGE, PRESIDENT, LOCAL 1923, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO, BALTIMORE, MD.

Mr. GAGE. Thank you. I might even be faster.

It is good to be here again. I have been a disability examiner since the early 1970s up in Baltimore, at the SSA central office, and I am also the president of one of the employees unions. AFGE represents about 55,000 Social Security employees nationwide so that the nature and the focus of this hearing is very important to us.

I think your key question is right on, why are the SSA disability determinations so frequently reversed, and I think there are some very obvious answers. Mr. Bunning is headed in the right direction, when he is looking for consistency.

In the program now, consistency comes from the ALJs. There is no Federal review of initial determinations, not one with any bite, not one with any meaning, not one that anyone even pays attention to.

I remember a number of years ago, I had to deliver one of these reports from central office on a certain State on their error rates, et cetera, and it was a southern State, and the head there, very hospitably, threw our report in the trash, without even looking at it, because it was useless to him.

What we need is a strong Federal review. We really need to federalize the DDSs. You cannot have consistency being applied by the ALJs. I do not think knocking out reconsideration or keeping reconsideration is really the problem. Some cases are resolved in reconsideration, but I do not think that will materially speed it up.

If you go right from the initial to the ALJ, I do not see the—think the reconsideration is a necessary stage.

Why are there so many ALJ reversals? Examiners look at a case saying can this person work, is the medical evidence sufficient, are his vocational factors there, so that we can make an objective decision. The ALJs do not do that. The ALJs look at it and say is this person working and are his reasons credible. So, there is really a different definition that is being applied between the initial and the ALJ stage, in practicality. So, to have, as the system is now, the ALJs apply that consistency I think is really a problem.

Second, I must ask the committee to please try to keep the whole program in view, as you are making your deliberations. Remember a few years ago, 10 years ago, the continuing disability reviews, CDRs, was the big question. They knocked a bunch of people off, and so we revised the CDRs. The CDRs right now are probably what this committee is going to be looking at in the next 2 or 3 years. Money is just hemorrhaging through the CDR process, because it is not being done. The government has to demonstrate that the person has improved. We do not have the administrative money to do that investigation, to have a consultative examination

for the claimant, so, therefore, benefits continue to be paid, the cases remain in the district office, no one looks at it.

Trial work period, moratoriums, it used to be 9 months, now it is up to 3 years where you continue paying benefits to a person where the initial disability determination implicated that the individual was going to improve or had a good chance to improve. We simply do not look at the cases and benefits continue to be paid. When a case does come in for recovery to our section that is responsible for recovery of overpayments, they are just simply waived, because again we do not have the manpower or we do not have the resources to go out and try to recoup that money.

So, I would really like the committee to keep the whole program in mind. I think the move to put more money up-front in the initial stage and face-to-face are all good ideas, but the whole program has to be looked at, and not just the one phase of the initial determination.

I do think our district office people also are well-equipped to do the face-to-face, whether they are disability examiners or not. They are trained to deal with people and they do a good job in dealing with them. But with the staff right now and where we are, I see this program as really having gone downhill during my years as a disability examiner, and we need some fundamental changes and some real help to get this program back on its feet.

Thank you.

[The prepared statement follows:]

STATEMENT OF JOHN GAGE, PRESIDENT,
LOCAL 1923, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
AFL-CIO

Mr. Chairman and Subcommittee Members:

I am John Gage, President of the American Federation of Government Employees (AFGE) Local 1923, AFL-CIO. I am here today on behalf of AFGE President John N. Sturdivant and the approximately 55,000 SSA employees that we represent nationwide. Thank you for the opportunity to testify regarding potential improvements in the SSA's disability program.

Mr. Chairman, in your announcement of this hearing you asked four questions. We would like to respond to each in its turn.

- Why are disability determinations so frequently reversed on appeal? Why is the reversal rate rising?

We believe that the high reversal rate and the upward trend of that rate are primarily the result of the SSA's inability to properly develop its cases. The main problem is not that we don't know how to do our job, but that we don't have the resources to properly develop and adjudicate the cases. This is true at all levels of the process including the state disability determination service units (DDSs).

First and foremost, there simply are not enough people to do the work. Disability does not exist in a vacuum. The same people who handle disability cases also handle every other type of claim for which SSA is responsible. Survivors and retirement claims, representative payees, medicare, non-receipt of checks, continuing disability reviews and each and every other post-entitlement are handled by the same beleaguered and demoralized staff. This staff labors valiantly to lend a kind and caring presence to the public but it is becoming increasingly difficult to do so. In the disability area alone, the disability initial claims backlog is expected to grow dramatically in the next two years. Senate staff estimate that at a cost of $500 per case, it would take $200 million per year just to keep the disability backlog at its current unacceptably high level.

Mr. Chairman, as you know, we have experienced a 25% reduction in staff since 1985. There has been a concomitant reduction in overall SSA funding. Our people no longer receive the training necessary to properly develop cases. Each SSA Regional Office now determines the extent and length of training. Those determinations are driven primarily by budget considerations. Historically, claims representatives (CRs) have received extensive training prior to being put on the front line. For many newly hired CRs, however, there is only on-the-job-training. There have been dramatic reductions in the number of disability examiners and benefit authorizers.

As a result of SSA's "downsizing", fewer and fewer employees have "quiet time when they are not meeting with claimants, to develop claims. This is time where one does not have to accept incoming phone calls, interview claimants, etc., and allows an employee to focus on the case before him. Also absent in most offices is time to stay current with incoming policy directives from the regional offices or central office. In the rush to do more with less and in order to make it look like the "downsizing" has had no ill effect on production, quality case development, has become a casualty. The result is that many more decisions are being appealed and the reversal rate continues to rise.

* Can SSA decision making be improved by expanding the information on which decisions are based? Would a face-to-face interview before an initial decision improve the quality of decisions?

Information upon which decisions are based should be expanded to include at least the items mentioned in H.R. 1799. An initial face-to-face interview is imperative. The current SSA practice of claimants having to fill out the so-called self-help disability application forms is a travesty. The form is lengthy, difficult, and intimidating, which cause claimants to make mistakes. No doubt many of the claimants errors are passed through to the DDS only to be caught at the administrative law judge (ALJ) level. Disability teleclaims should also be terminated. Teleservice centers and field offices send applications out to claimants to be filled out and returned. The interview is then conducted over the phone. Consequently, there is no visual observation whatsoever of the claimant whose application is denied until appeal to the ALJ. This undoubtedly contributes to the high error rate.

The opportunity for an evidentiary hearing is an excellent approach. However, a major problem with the approach is that the DDS sites are quite limited. There is generally only one in each state. We recommend that field office staff be trained in the medical aspects of disability cases, in order that they could perform a type of evidentiary hearing. This would minimize the inconvenience to the applicant and should prove to be cost effective as well.

Another major problem with the disability application process is that approximately 600 contact stations have been eliminated by the Agency since 1985. De facto, access is denied to many, particularly the severely disabled, when SSA field representatives (FR) no longer travel to these sites to take claims. Similarly, FRs very seldom go to the homes of the severely disabled as they once did. According to a recent GAO study (HRD 91-63), as a result of the downsizing the FR position has suffered the greatest percentile decrease (48%) of all professional staff in the field offices. Generally, they also happen to be the most highly trained, experienced and senior SSA field staff. Those who are left tend to stay in the office handling initial claims. Clearly the disability case development process suffers as a result of this skilled staff loss.

* What can be done to improve the timeliness of SSA decisions?

The answer is "...Do it right the first time!" An initial face-to-face interview by highly knowledgeable and well trained staff will do more than any other single procedural approach to shorten the processing time which enhances the rights of claimants. Also, of course, we need more people at all levels including personnel at the DDSs. A well researched and properly documented disability case simply takes time, and quite simply, at present, there are more cases than there are people to handle them in an acceptable time period.

* Should there be DDS advisory groups to help improve accuracy?

We would support a demonstration project to examine this approach. Similarly, advisory groups to look at the SSA's initial application process should

be part of the project.

In summary, most of the current problems will only be curtailed by more staff with enhanced training. This would shorten the processing time and lower the reversal rate.

AFGE is eager to work with the Committee in any way that we can. We have been appearing before you on SSA issues for many years and we continue to appreciate and support your many efforts to maintain and enhance the Social Security program.

That concludes my statement. I will be happy to answer any questions.

Chairman JACOBS. Thank you, Mr. Gage.
Mr. Christopher.

STATEMENT OF TOM CHRISTOPHER, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS, ACCOMPANIED BY CARROLL D. MOORE, CHAIRMAN, LEGISLATIVE COMMITTEE

Mr. CHRISTOPHER. Chairman Jacobs and members of the subcommittee, I am Tom Christopher, president of the National Association of Disability Examiners. Appearing with me is Carroll Moore, our legislative chair.

Our membership consists primarily of DDS personnel who basically develop, evaluate and make disability decisions on a daily basis. We believe what you are discussing today are probably the most relevant issues facing our program today. We appreciate being invited to share our opinions with you.

One of the questions is why are so many ALJ reversals occurring. When you look at the data, 37 percent of initial claims are allowed and 17 percent of reconsideration claims are allowed by the DDSs, with 95 percent accuracy, and yet two-thirds of the claims that go to ALJs are reversed by the ALJs, you have got to ask the question why.

Now, a quick conclusion to that is that either the ALJs are not doing their job or the DDSs are not doing their job. We think that is a misperception. We believe the primary reasons for the perceived discrepancies are twofold: There are different rules and different quality review approaches that happen at ALJs versus the DDSs; and, second, the DDS decisionmakers have much less professional discretion than the ALJ decisionmakers.

For example, ALJs directly apply the rules and regulations. ALJs quality review process is such that encourages case adjudication on a case-by-case basis, and they are encouraged to apply their professional discretion. DDS decisionmakers follow the POMs, which is an interpretation of the rules and regulations. The quality review process encourages a cookbook approach to determinations, and professional discretion is really not encouraged in the DDSs.

Another factor is the passage of time. Over a year normally goes by. Thus, we believe that comparing decision outcomes in DDSs versus ALJs is somewhat like comparing apples and oranges. Some really quick conclusions could be drawn.

Can the decisionmaking be improved and is face-to-face the answer? Any process can be improved. We do not believe that face-to-face interviews are the right answer. In fact, we believe that would be a mistake to the program. We do believe that evidentiary hearings is a possibility. We would encourage evidentiary hearings be used to enhance the reconsideration process.

We really think the better approach would be, but it may not be palatable, that if the DDS decisionmakers were afforded the same latitude of professional decisionmaking as the ALJs have, and if the quality review process for DDSs is parallel to that of the ALJs, you would have a much more cost-efficient approach, many claimants would be allowed much more quickly, and you would have no structural changes. That we think is the most quick way to approach this situation.

That requires some fundamental changes, though, as far as thinking goes.

As far as how could the processing time be improved, processing time is directly related to staffing. Obviously, the Hardy administration changes have caused major staffing shortages and, thus, processing time is being affected. The appropriations recently done are going to help a lot.

We do believe, though, that everybody needs to understand that it is not only the dollars appropriated, but the lead time that is needed. Both of those factors should be considered, in order to have the cases processed in a more efficient way. The management of budget by crisis is not helping anybody out.

In conclusion, I would like to leave you with the following thoughts: First, if the disability program is to provide quality service, adequate funding, with appropriate lead time is absolutely essential, and that lead time is something that sometimes is easily forgotten.

Second, comparing DDS decision outcomes with ALJ outcomes is like comparing apples and oranges.

Third, any face-to-face experience must be coupled with increased professional discretion by the decisionmaker. If anyone believes that a face-to-face interview under the current rules and current regulations are going to make any major changes, you are making a major mistake. Increased professional discretion has got to accompany any face-to-face experience.

Mr. Chairman and subcommittee members, we appreciate being invited and share our views with you.

Thank you.

[The prepared statement follows:]

STATEMENT OF TOM CHRISTOPHER, PRESIDENT, AND CARROLL D. MOORE, LEGISLATIVE CHAIRMAN, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Chairman Jacobs and members of the sub-committee:

I am Tom Christopher, President of the National Association of Disability Examiners. Appearing with me is Carroll Moore, NADE's Legislative Chairman. The issues to be discussed today are some of the most important facing our Disability Program. NADE's membership is composed primarily of DDS personnel. We develop, evaluate and make disability decisions on a daily basis.

We will briefly address the four specific issues you have identified in the announcement.

1. WHY ARE SSA DECISIONS FREQUENTLY REVERSED BY ALJ'S?

Currently 37 percent of all initial claims and 16 percent of all reconsideration claims are allowed by the DDS. SSA Quality Assurance data indicates 95 percent of the claims are adequately documented and have the correct decision. Yet, 60+% of cases appealed to OHA are allowed. The quick conclusion is that either the DDSs or the ALJs are not doing their job. NADE believes that neither of these are true. The primary reasons for the perceived discrepancy are due to the different rules used and the level of professional discretion allowed. Consider the following:

A. The DDS decision-maker must follow the POMS, which is SSA's interpretation of the Regs and Rulings while the ALJs directly apply the Regs and Rulings.

B. The DDS decision-makers have limited ability to use professional discretion, while the ALJs have complete authority to use their professional discretion.

C. The differences in the quality review processes. DDS decisions are subject to a very stringent review process. This encourages the DDS decision-makers to make "cookbook" decisions. ALJ decisions are subject to a much more liberal review process. This encourages the ALJ decision-makers to make decisions on a case-by-case basis.

D. The passage of time. Frequently the ALJ decisions are made over a year after the last DDS decision.

Simply put, comparing the decision outcome between DDS's and OHA is like comparing apples with oranges.

2. CAN SSA DECISION-MAKING BE IMPROVED? WOULD A FACE-TO-FACE INTERVIEW ON THE INITIAL LEVEL IMPROVE THE QUALITY?

Obviously, any process can be improved and we all must work together to facilitate that improvement. NADE believes the extent of the documentation in DDS decisions is markedly improved from the 1980 era. The quality could be improved if more complete information was obtained by the local Social Security Field Office when the claim is taken. There has been a significant drop in the quality of this information which is a direct result of the fervent down-sizing by the Hardy administration. SSA's current policy to have more reliance on teleclaims and claimant-completed forms is a step in the wrong direction.

NADE believes the most cost-efficient solution is to provide the DDS decision-maker the same degree of professional discretion ALJs have, and to have the SSA Quality Review for DDS decisions parallel the quality review for ALJ decisions. NADE strongly believes a face-to-face interview at the initial level would be a monumental mistake. Any face-to-face experience must be coupled with providing increased discretion to the decision maker. If you conclude the only answer is a face-to-face

experience earlier in the claims process, then NADE recommends the reconsideration process be enhanced to provide a formal evidentiary hearing for those claimants who would be denied in the reconsideration paper review. NADE's attached position paper, Exhibit A, provides more details.

3. WHAT CAN BE DONE TO IMPROVE TIMELINESS?

NADE believes there is a direct correlation between needed staffing levels in the DDSs and a reduction in processing time. Currently, thanks to the down-sizing by the Hardy administration, the DDSs are severely understaffed and processing times are soaring. The recent release of the $100,000,000 from the Contingency Fund and the $232,000,000 Supplemental Zebley Appropriation will help. However, it takes DDS's over a year to recruit, hire and adequately train new staff. The Congress and SSA must provide the needed funding with sufficient lead time to allow DDS's to staff-up to handle the workload. This on-going funding by crisis is a disservice to the disabled population.

4. WOULD THE ESTABLISHMENT OF DDS ADVISORY GROUPS IMPROVE DECISION ACCURACY?

Most government organizations tend to be over-insulated and the Disability Program is no exception. This was especially evident during the Hardy administration when input was neither requested nor heard. NADE believes the King administration has made great strides in this area. We believe the creation of any advisory groups now is ill-timed and would more likely create confusion than promote consistency. NADE believes Commissioner King has demonstrated good faith and she deserves more time to improve the service delivery and the quality of the program.

Conclusion

In closing, we want to leave you with the following thoughts.

1. If the Disability Program is to provide quality service, adequate funding with appropriate lead time is essential.

2. Comparing DDS and OHA decision outcomes is like comparing apples and oranges.

3. Any face-to-face experience must be coupled with more professional discretion by the DDS decision-maker.

4. Face-to-face interviews at the initial level would be a monumental mistake. NADE endorses enhancing the current reconsideration process with evidentiary hearings on those claims which would be a denial on the basis of the paper review.

Mr. Chairman and sub-committee members, NADE appreciates your invitation to be here and this opportunity to share our views.

EXHIBIT A

POSITION PAPER

FACE-TO-FACE INTERVIEWS

The current structure of the Social Security Disability Program provides our claimants who have been denied benefits the opportunity for a face-to-face meeting with the actual decision-maker at the Administrative Law Judge (ALJ) level. For over two decades there has been extensive debate within and outside the Social Security Administration (SSA) on the merits of providing this face-to-face experience earlier in the disability claims process. SSA and the state Disability Determination Services (DDS) have conducted many different pilots on this concept.

The major reason to provide our claimants with a face-to-face experience earlier in the process is to improve the quality of service - both to improve the quality and accuracy of the decisions and to reduce the time it now takes for many claimants to receive a favorable decision.

The General Accounting Office (GAO) studied many of the pilots conducted by SSA and concluded in its April 1989 report:

> "such (face-to-face) interviews would have little effect if the (DDS) claims examiners, in justifying their decisions, were not allowed to use their personal evaluation, based on the interview of the claimants' impairments and credibility. If (DDS) claims examiners are given this discretion, they may be able to identify some claims that would almost certainly be approved by the ALJ and keep these cases out of the SSA (ALJ) Hearing Offices."

Historically, our claimants have experienced a higher rate of favorable decisions at the ALJ level - the current ALJ reversal rate is 50 - 60 percent. This high reversal rate has led many to conclude that if the face-to-face experience was simply provided earlier in the process, a large number of claimants would more quickly receive the benefits they deserve.

The National Association of Disability Examiners (NADE) is the professional association whose membership is composed primarily of DDS personnel. All of the current administrative and congressional proposals involve having the face-to-face experience at either the initial or reconsideration level. Since all initial and reconsideration decisions are made in the DDSs, NADE is in a unique position to participate in this dialogue and offer a proposal, based on the actual working experiences of NADE members.

At our Mid-Year Board Meeting in March, 1991, NADE discussed the perceptions about the need for face-to-face meetings between our claimants and the DDS decision-maker. NADE believes the most cost-effective approach to provide those claimants who are disabled an allowance at the earliest point would be to extend the same professional discretion to the DDS decision-maker that the ALJ's currently have, and to have the SSA quality review for DDS decisions parallel the review approach of ALJ decisions. If this was done, NADE believes the decisional outcomes between the DDS decision-makers and the ALJ's would be much closer. This would require a radical change in the mind-set of the DDS decision-makers and SSA. However, NADE believes this approach should be done, at least on a pilot basis, before major structural changes occur.

NADE recognizes that the Congress wants to have the face-to-face experience earlier in the claim process. NADE believes there will be considerable reluctance to provide this needed change in professional discretion by the DDS decision-maker without regulatory changes.

If the climate is such that the most cost-efficient approach is not possible, then, NADE recommends that the initial claims process be retained as is and the current reconsideration process be enhanced to provide a formal evidentiary hearing for those claimants who would be denied in the reconsideration paper process. This process would allow the DDS decision-maker to make a totally favorable decision without a hearing, if possible.

NADE took this position based on the following conclusions:

- The initial process is a valuable screening step and provides for prompt benefits to 35 - 40 percent of our claimants.

- NADE strongly believes a face-to-face interview at the initial level would be a monumental mistake. Any face-to-face experience must be coupled with providing increased discretion to the decision-maker.

- Any face-to-face interviews held without additional discretion to the DDS decision-maker will have little effect on the outcome of decisions and will add substantial cost and time to the claims process.

- The reconsideration process, the current first level of appeal, has lost much of its credibility to our claimants, the legal community, the advocacy groups and the Congress. Even though 10 - 15 percent of appealed initial denials are currently reversed to an allowance during the reconsideration process, the common perception is that this is a rubber-stamp process. However, NADE believes the current reconsideration process needs to be retained and enhanced by providing for an evidentiary hearing for claimants who would be denied on the paper review.

- Evidentiary hearings, similar to the hearings currently afforded to our claimants who appeal the termination of their Social Security Disability Benefits, provide the decision-maker with the needed discretion to apply their professional judgment. This hearing process is already being conducted by State Disability Hearing Units (DHU) and this process is already in SSA regulations.

- The quality review process currently used by SSA's Disability Quality Branches (DQB) for DHU evidentiary hearings which is parallel to the ALJ quality review process should be followed in the new evidentiary process we propose.

NADE believes evidentiary hearings for probable denials at the reconsideration level have the potential to improve the overall service to our claimants by affording them the opportunity to present additional pertinent information. Evidentiary hearings will permit observations by the DDS decision-maker which are now unavailable. We believe the concept of evidentiary hearings will enhance the ultimate fairness of the decision-making process for our claimants and improve the credibility of the first level of appeal. We believe the evidentiary hearings will enhance the disability examiner's role as the decision-maker.

NADE has some major concerns about any changes in the structure of the disability claims process. <u>These issues must be addressed before any changes are made. These issues include adequate funding, quality training, and realistic implementation timelines</u>.

<u>Adequate Funding</u> - It will cost a significant amount of money to replace the reconsideration step with evidentiary hearings. This initiative will result in decreased DDS productivity due to the travel required and the additional time needed to conduct the evidentiary hearings. It is absolutely imperative that both SSA and the Congress provide adequate funding. If, for any reason, this is not possible, then this initiative is doomed for failure.

<u>Quality Training</u> - NADE strongly recommends that all DDS disability examiners who will conduct evidentiary hearings receive quality training. The training at McGeorge School of Law that continues to be offered to Disability Hearings Unit examiners has proven to be outstanding and has provided an excellent basis for quality.

<u>Realistic Implementation Timelines</u> - As a result of substantial downsizing in the DDSs and over-realization of projected workloads, the Disability Program is currently facing a workload/staffing crisis. The overload will be worse when DDSs process the Zebley workload. Implementation of the evidentiary hearing initiative at

this time would result in a grid-lock in the system and all claimant service would plummet.

DDS's will need sufficient leadtime to recruit, hire, train and get into production an adequate number of new examiners that will then permit the utilization of senior level examiners to conduct the evidentiary hearings. We have emphasized before, and do so again, that new examiners are not really productive during their first 9 to 12 months on the job. It also takes up to a year for DDS's to work through state personnel systems to recruit and hire new staff. Thus, the implementation plan will need at least two years of leadtime to allow DDS's to hire and train needed staff. This two year timeline would provide SSA the time to work through the needed program changes while allowing DDS's to gradually staff-up and be prepared for full implementation in Fiscal Year 1994.

In summary, NADE believes the most cost-effective approach is to provide the DDS decision-makers with the same professional discretion in decision-making that the ALJ's currently have and to have the SSA quality review for DDS decisions parallel the quality review for ALJ decisions. If the current climate does not allow for this most cost-effective approach, then NADE believes the current reconsideration process should be enhanced to provide for a formal evidentiary hearing for those claimants who would be denied in the reconsideration paper review. This process should model the current DHU process, providing the DDS decision-maker with the needed discretion to apply professional judgment on a case-by-case basis. This evidentiary hearing process would require a significant funding increase and at least a two year leadtime before implementation.

Chairman JACOBS. Thank you, Mr. Christopher.
Mr. Goldstein.

STATEMENT OF STEWART GOLDSTEIN, SECRETARY, CHAPTER 224, NATIONAL TREASURY EMPLOYEES UNION, CLEVELAND, OHIO

Mr. GOLDSTEIN. Thank you, Mr. Chairman.

My name is Stewart Goldstein. I have been an attorney-adviser with the Social Security Administration's Office of Hearings and Appeals for over 15 years, and I am here today on behalf of the National Treasury Employees Union, which represents attorneys in 96 OHA offices across the country.

As you noted in your statement, more than half the total processing time involved in the administrative decision process is at the hearing level, and if a decrease in processing time is not addressed at that level, you will have a difficult time significantly decreasing the processing time.

As you just heard, I agree that if you do not give ALJ independence at the initial level, you are not going to substantially change the reversal rate, because I think that is a major reason for the reversal rate at the ALJ level. I do not think you need two ALJ hearings.

However, based on my years of experience with SSA, I think a prehearing conference and recommended decision program would speed processing time and improve the quality of the decisions.

Mr. Enoff mentioned this to you. However, I think it is the attorney-advisers in most of the pilot projects that hold the prehearing conferences for the ALJs. They review and analyze the case, and in some of the pilot projects prepare recommended decisions for the administrative law judge—only in fully favorable cases. The ALJ can then accept the recommendation or proceed with the normal processing of the case.

This leads to ultimate decisionmaking in the hands of the ALJ, but provide a mechanism for early review and payment by highly knowledgeable attorneys of cases that clearly warrant reversal, but will not be seen for analysis by the ALJ in the decision process, perhaps for months. If the normal process is followed, we believe that the essence of this project should include prehearing conferences conducted by attorney-advisers, under the auspices of the ALJ. That would develop the record without the detailed review of the ALJ, which cannot usually be accomplished until shortly before the hearing because of backlogs and production problems that the ALJs face.

As part of the program, the attorney would be able to enter into stipulations and agreements with represented claimants that would narrow the scope of any supplemental hearing or any full hearing, and focus the issues for the administrative law judge.

Finally, we believe that preparing recommended decisions in fully favorable cases—those cases where the person is clearly disabled, will significantly decrease processing time. This would be particularly true in those cases that are most compelling, because those are the people that clearly should be paid, and if there was

someone with the ALJs independence or under his auspices reviewing the case, they would be paid.

We request that the Social Security Subcommittee express its desire to see these points in the prehearing conference program that SSA apparently is going to implement shortly.

Thank you.

[The prepared statement follows:]

STATEMENT OF STEWART GOLDSTEIN, ATTORNEY-ADVISOR, SOCIAL SECURITY ADMINISTRATION, NATIONAL TREASURY EMPLOYEES UNION

My name is Stewart Goldstein. I have been an Attorney Advisor with the Social Security Administration (SSA), Office of Hearings and Appeals (OHA) for over 15 years.

I am here today on behalf of the National Treasury Employees Union which represents attorneys in 96 OHA offices throughout the country. I appreciate the opportunity to appear and comment on H.R. 1799.

More than half the total processing time for an administrative decision occurs at the hearing level. It will be difficult to make inroads in overall processing time if you focus only on the initial and reconsideration levels. Even with the elimination of the reconsideration level, a face-to-face "hearing" at the initial level and more intensive development of the record, may well consume any savings in processing time.

Further, in my opinion, such changes are unlikely to provide a more satisfactory decision to claimants and their representatives, at the initial level. It is not the face-to-face nature of the OHA hearing, nor the development of the record that has resulted in public confidence in the hearing level of the process. Rather, it is the fact that the hearings are held before, and the development performed at the direction of an independent Administrative Law Judge (ALJ). To move the appearance of due process to the initial determination level, without providing a Hearing Officer with the independence of an ALJ will, I believe, be of little value in improving the quality of the initial determination.

Based on my years of experience in the SSA appeals process, I am convinced that the following proposal will result in a more efficient and quicker adjudication process and in fact improve the quality of the ALJ decision without the budget burden that other plans may entail.

We propose the implementation of a Pre-Hearing Conference and Recommended Decision program at OHA. The program would have a GS-13, 14 Attorney Advisors, with years of OHA expertise and experience working with ALJ's, review and analyze the case as it comes into the office and initiate any development of the record that is needed. Currently, in most offices a case must be placed on an individual ALJ's docket and reviewed by that ALJ before development can begin. Often, ALJ's are unable to perform a detailed review of a file until shortly before the hearing. Precious weeks, and even months, are wasted in the decision process.

Under our proposal, in addition to reviewing and analyzing a case, an Attorney Advisor may prepare a fully favorable Recommended Decision to the ALJ. The ALJ could adopt the Recommended Decision, issue aeparate favorable decision, or proceed with the normal hearing process as if no recommendation was made. While leaving the decision ultimately in the hands of the ALJ, this provides a mechanism for early review and payment by highly knowledgeable attorneys (under the auspices of the ALJ) of cases that clearly warrant reversal. It should substantially reduce processing time.

Attorney Advisors would be permitted to enter into agreements with counsel for represented claimants (subject to acceptance by the ALJ), narrow the issues and focus the scope of the subsequent oral hearing. It would allow ALJ's to concentrate their time on the more difficult issues truly in controversy.

Unrepresented claimants would be notified of their right to be represented by counsel, of the issues in the case, and any needed development by the Attorney Advisor. While a fully favorable Recommended Decision could be prepared, no stipulations or agreements would be entered into with unrepresented claimants to assure their due process rights are protected at each step of the process by the ALJ.

Thus the essence of our proposal is a Pre-Hearing Conference and Recommended Decision program that would be totally voluntary. Both claimants and counsel would have to opt into the program and could subsequently opt out at any time. It would provide for:

1) Pre-Hearing Conferences with claimant's representative and agency Attorney Advisors;

2) Development of the record by the Attorney Advisor;

3) Entering into stipulations and agreements between claimants counsel and an Attorney Advisor; and

4) Preparing a Recommended Decision by the Attorney Advisor in fully favorable cases, subject to acceptance or approval of the ALJ.

This program would benefit all of the parties involved in the decision process. All claimants would get their decisions more quickly and the most compelling, those cases representing the most clearly disabled, will be helped the most. The most time intensive part of the program, the review and analysis of the case, is already performed by the Attorney Advisor after the hearing in order to draft the decision. This plan simply moves some of that review and analysis time to the pre-hearing stage.

The ALJ's would be free to concentrate on the more difficult issues still in controversy and those issues will be more focused and the record more fully developed in those cases requiring hearings. There should be fewer postponements because the claimant was not aware of his right to counsel or because of an incomplete documentary record. Fewer supplemental hearings should be required.

Additionally, SSA will benefit from the decreased processing time and better decision process. ALJ's can be more productive and have more time for the difficult issues requiring their expertise.

A program similar in many respects to this was in fact recommended by the SSA Disability Advisory Committee in its' July 1989 report. Moreover, acting Chief Judge Jose Anglada of OHA reports that the Administrative Conference of the United States has endorsed the use of Pre-Hearing Conferences. The OHA itself has initiated a pilot project in 15 offices this past year and Judge Anglada concludes that it is a valuable tool in decreasing processing time and in improving pre-hearing development. ALJ's, claimant's representatives, and Attorney Advisors all felt that it was a valuable program. We are optimistic about the indication by Acting Associate Commissioner Andrew Young that nationwide implementation is forthcoming.

We respectfully request that the Social Security Subcommittee express to the SSA a desire to see a Pre-Hearing Conference and Recommended Decision Program implemented on a nationwide basis along the lines of the program that I have outlined here today:

1) Pre-Hearing Conferences conducted by GS-13, 14 Attorney Advisors, who would;

2) develop the documentary record at the pre-hearing stage;

3) enter into stipulations and agreements with claimants counsel; and

4) prepare Recommended Decisions in fully favorable decisions;

all subject to the acceptance and approval of the Administrative Law Judge.

Thank you for your kind consideration. I would be happy to answer any questions.

Chairman JACOBS. Thank you, Mr. Goldstein.

Mr. Bunning.

Mr. BUNNING. I have a couple of questions for Mr. Christopher.

If we change the rules and allowed the same rules for the DDSs, what percentage of the claimants do you think would be finally approved at that level in comparison to those who now go on to the ALJs?

Mr. CHRISTOPHER. My best guess, and this obviously is only a guess, would be, without a face-to-face interview and simply giving the increased latitude in decisionmaking, my guess would be that you would probably see about a 20 percent earlier outcome.

Mr. BUNNING. Earlier outcome. Right now 70 percent of the favorable case dispositions are done at the first level now?

Mr. CHRISTOPHER. What I am saying is that at least 20 percent of those cases that go to the ALJs and the ALJ eventually allows would be allowed without question at the first step. Now, if you couple that with a face-to-face experience, that obviously would go up.

Mr. BUNNING. You also think the quality of the decisionmaking process at the first level, then, would also be improved a great deal?

Mr. CHRISTOPHER. In my opinion, it would be improved, yes.

Mr. BUNNING. That is all I have. Thank you, Mr. Chairman.

Chairman JACOBS. Well, we appreciate the succinct contribution of the panel to the record.

Thank you.

Our next panel consists of Legal Aid Bureau, Inc., Baltimore, Maryland, represented by Ethel Zelenske; Legal Services of New York City, Barbara Samuels; National Organization of Social Security Claimants Representatives, Meyer Silver; and Legal Assistant Foundation of Chicago, Nancy Katz.

Ms. Zelenske, we ask that you hit the seat talking.

STATEMENT OF ETHEL ZELENSKE, CHIEF ATTORNEY, LEGAL AID BUREAU, INC., BALTIMORE, MD.

Ms. ZELENSKE. My name is Ethel Zelenske. I am the Chief Attorney of the Administrative Law Unit at the Legal Aid Bureau, in Baltimore, where I have worked for over 13 years.

I applaud any efforts to improve the disability determination and appeals processes. The delays are currently so long and the documentation so poor that clients are dying before they ever see their checks.

My colleagues and I represent hundreds of clients before SSA annually, and the cases described today and in my written statement are, unfortunately, not isolated incidents.

Last summer, Ms. C. came to my office for help with her Social Security case, which was at the hearing level. She was 62 years old and suffering from colon cancer. As I escorted her to my office, the evidence of her suffering was overwhelming. She was hunched over, could barely walk, and was very weak. Sitting in my office, she was in obvious pain, and we cut the interview off after less than a half hour, because she was too tired and in too much pain to continue.

She had worked most of her life, but was forced to stop working in April 1989, because of weakness. In September 1989, she was diagnosed as having colon cancer, and filed for SSI. She was hospitalized over the ensuing months for surgery. However, her condition deteriorated. Her application was denied on the basis that she could return to past work as a sewing machine operator in a factory.

The only evidence in her Social Security file consisted of hospital records. No other evidence, neither letters nor assessments were obtained. The only residual functional capacity form was one completed by a DDS physician, who found, remarkably and without ever having seen her, that she could lift 50 pounds and stand for 6 hours a day.

By the time she came to my office, it was readily apparent that time was of the essence. I dealt directly with the ALJ who issued an expedited decision, without a hearing, on July 25, 1990, the same day Ms. C. died.

A week later, her daughter called me. She was furious and convinced that a conspiracy existed to cheat her mother out of the benefits. How was she to be convinced otherwise? While it is not a conspiracy, the process is indifferent and insensitive to applicants. Ms. C's case illustrates many of the problems encountered by disability claimants.

The high reversal rate at the hearing level has several causes, including the Social Security Administration's failure to obtain complete and updated documentation from all treating sources, its failure to properly explain the disability standard to treating sources, or ask questions relevant to the disability determination process, its failure to obtain residual functional capacity assessments from treating and consultative sources, and, finally, its failure to properly evaluate the evidence which exists.

Despite the severity of the current problems, the system is not beyond change. Face-to-face interviews should be implemented at the hearing level. If Ms. C. had been seen at such an interview, it would have been apparent that she could not lift 50 pounds or stand for 6 hours a day. There is no substitute for seeing the claimant.

Second, medical records from all treating sources should be obtained and continually updated. When information is received, it should be reviewed to determine if further documentation is needed.

Third, treating sources should be sent letters or forms individualized to the specific case.

Fourth, residual functional capacity assessment should be obtained from treating sources and consultative examiners. SSA should abandon its policy that only a nonexamining DDS physician can make an RFC determination.

Finally, SSA should abandon its policy of nonacquiescence and be required to follow Circuit Court precedent.

The other major problem encountered by disability claimants is delay. I have two suggestions: First, eliminate reconsideration. It is not needed, especially if Social Security obtains better documentation up-front, and performs face-to-face interviews. Second, time limits should be imposed. Claimants are currently experiencing

very long delays, up to 1 year at the ALJ level, and another year before the Appeals Council.

I feel that if these changes are made, there would be no need for a Social Security Court. Such a court will not correct the process where change is most needed, namely, up at the beginning. The Federal courts have provided a body of well-established rules from which our clients have benefited.

Thank you.

[The prepared statement follows:]

STATEMENT OF ETHEL ZELENSKE, ESQ.
LEGAL AID BUREAU, INC.
BALTIMORE, MARYLAND

BEFORE THE SUBCOMMITTEE ON SOCIAL SECURITY,
COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON SOCIAL SECURITY ADMINISTRATION
DISABILITY DETERMINATIONS AND APPEALS PROCESS

MAY 2, 1991

I am submitting this Statement at the invitation of the Subcommittee on Social Security and on behalf of specific clients of the Legal Aid Bureau who have sought social security benefits. I am the Chief Attorney of the Administrative Law Center of the Legal Aid Bureau, a statewide program which provides legal services to indigent residents of Maryland. The Legal Aid Bureau represents hundreds of clients annually before the Social Security Administration and on appeals in the federal court system. I have been representing clients in social security cases since 1979 and have been involved in litigation against the Social Security Administration.

The process of making disability determinations requires change. The problems encountered by clients with delays in the system and poor documentation can be remedied, and, if implemented, would improve the process greatly.

These problems are best exemplified by the cases of two clients represented by the Legal Aid Bureau within the past year. In each case, the Administrative Law Judge (ALJ) made a decision on the record without the necessity of a hearing; the Disability Determination Service (DDS) failed to obtain necessary documentation; and lengthy delays were encountered in the administrative process. Sadly, both clients died from the alleged nondisabling impairments after receiving the favorable ALJ decisions but before payment was effectuated.[1/]

MS. C.

Ms. C. applied for Supplemental Security Income benefits on September 26, 1989, when she was 61 years old. She suffered from colon cancer and anemia and had stopped working as a housekeeper earlier that year. Despite these diagnoses, her application was denied on February 5, 1990. A request for reconsideration was filed on February 7, 1990

1/ Payment of retroactive benefits to survivors after a claimant receives a favorable decision but before negotiation of the check is extremely limited in SSI cases. See 20 C.F.R. §416.542. On the other hand, in Title II cases, various family members and the estate are eligible to receive the underpayment. See 20 C.F.R. §404.503.

and was denied on April 23, 1990. The reconsideration denial was made on practically the same date as Ms. C. was taken to an emergency room hospital feeling weak and suffering from severe anemia. At both the initial and reconsideration levels, DDS found that Ms. C. could return to past relevant work as a sewing machine operator. The only records in the file were from hospitals where Ms. C. had received surgery for her cancer. Despite her impairment, age and other limitations, the DDS physician completed a Residual Functional Capacity (RFC) form which found that she could occasionally lift 50 pounds, frequently lift 25 pounds and stand for six hours in an eight-hour workday.

Ms. C. requested a hearing on May 1, 1990. Her initial interview with me at the Legal Aid Bureau was on June 14, 1990. At that time, Ms. C. could barely walk and was severely hunched over in pain. She appeared to be in a very weak and emaciated state. It became readily apparent that time was of the essence in this case and I asked the ALJ to make an expedited decision. This decision was finally issued on July 25, 1990, the same day that Ms. C. died.

The denials at both levels in Ms. C.'s case were based on the fact that there was no metastasis of the cancer. However, there were no letters from treating physicians or consultative examinations. The only RFC in the file was one done by the DDS physician. Given Ms. C.'s age, education and vocational history, there was simply no reason why she was not found disabled pursuant to the Medical Vocational Guidelines. The tragedy of this case is that had DDS properly documented Ms. C.'s case, had the delays been eliminated and had DDS seen Ms. C. in person, the quality of life in her last months would have been greatly improved by receiving the SSI benefits to which she was clearly entitled.

MR. G.

Mr. G. applied for SSI on September 15, 1989, when he was 41 years old. It was denied on November 16, 1989. He suffered from numerous serious impairments including alcoholism and drug addiction, liver disease, pancreatitis, high blood pressure, seizure disorder and renal insufficiency. In November, 1989, while he was hospitalized for pancreatitis and on the same day that he was denied benefits at the initial level, a diagnosis was made that he was HIV positive.

Mr. G. filed for reconsideration on January 8, 1990, while hospitalized in a state psychiatric facility. It was also at that time that his social worker made the first contact with an attorney at the Legal Aid Bureau. Despite the attorney's submission of evidence, his request for reconsideration was denied nearly seven months later on August 9, 1990. A request for hearing was filed and an Administrative Law Judge decision was made on the record without the need for a hearing on February 25, 1991. The only new medical evidence submitted to the Administrative Law Judge was a statement from Mr. G.'s mother who is testifying before the Subcommittee today.

Mr. G. had an appointment at a Social Security office on March 19, 1991 to discuss his financial eligibility for SSI. Before payment could be effectuated, he died in early April, 1991.

At the reconsideration level, records of numerous hospitalizations including the psychiatric admission from December 11, 1989 to January 11, 1990 were submitted. The discharge summary for the psychiatric hospitalization diagnosed poly-substance dependence, passive-aggressive personality disorder, fracture of the fourth finger of the right hand, high blood pressure, HIV positive and history of pancreatitis. On the SSA reconsideration disability report form, Mr. G. stated in his own words that he needed to rest much of the day due to weakness and was in pain, requiring supervision outside of the home.

Despite these records, the DDS physician made a physical RFC determination that was strikingly similar to the one made for Ms. C., finding that Mr. G. could occasionally lift 50 pounds, frequently lift 25 pounds, stand six hours in an eight-hour workday and sit six hours. The reconsideration denial found no evidence of positive physical or mental findings, concluding that Mr. G. had "the ability to perform many jobs."

Based on these same records and impairments, the ALJ made a favorable decision on the record without the necessity for a hearing. In contrast to the DDS finding that the evidence did not establish a "severe" nonexertional impairment, the ALJ found, in relying also on Mrs. G.'s statement, that Mr. G. suffered from a serious nonexertional impairment which would significantly compromise his ability to work.

In this case, due to the unreasonable delays at the reconsideration level (8 months) and the failure of DDS to properly evaluate the evidence, Mr. G. also died before he could receive the SSI benefits to which he was entitled.

The improvements addressed in the proposed legislation would help reduce unfortunate situations like those of Ms. C. and Mr. G. where delays and the failure of DDS to obtain proper documentation contribute to the suffering of eligible claimants.

I. WHY DECISIONS ARE FREQUENTLY REVERSED.

It is the experience of Legal Aid Bureau staff that there are several reasons why decisions are so frequently reversed at the ALJ level. First, DDS fails to obtain documentation. They frequently miss treating sources altogether, treating the case as static. However, it is obvious that impaired claimants' cases are not static and that they are often hospitalized as their conditions change between the time the initial application is filed and through reconsideration. We find that this information is often not utilized nor obtained by DDS. Clients have often cited in their request for reconsideration or hearings that all of the available medical information was not considered by SSA.

Further, even if DDS sends a request to a treating physician, they fail to ask questions relevant to the

disability determination process. For instance, in Mr. G.'s case, Form SSA-3826-F4 (Medical Report - General) was sent to his treating physician. This form has no questions on it and only asks for five types of information: (1) history; (2) physical findings; (3) laboratory studies; (4) diagnoses; and (5) treatment and response. Doctors are not educated about the standards for disability determinations nor are they asked questions relevant to determining whether an individual can engage in substantial gainful activity. This failure to ask for relevant information from treating physicians was a critical shortcoming in both Ms. C.'s and Mr. G.'s cases.

Second, SSA fails to obtain a RFC from the treating source or from a consultative examination, even though one is required in the latter case under Social Security Ruling 82-14. Obtaining a RFC is critical since it analyzes the medical findings and provides a medical assessment of the ability to do work-related activities. In neither Mr. G.'s nor Ms. C.'s was a RFC obtained. Particularly for Ms. C., an RFC would have been extremely helpful given her advanced age, unskilled work history and ninth grade education.

Third, SSA fails to properly evaluate the evidence that does exist since it applies incorrect standards, namely, the failure to apply circuit precedent due to the policy of non-acquiescence. This results in several rules which are particularly helpful to evaluating a case not being applied. For instance, in the Fourth Circuit, there is a well-established rule regarding the weight to be given to a treating physician's report. See, e.g., Coffman v. Bowen, 829 F.2d 514 (4th Cir. 1987); Mitchell v. Schweiker, 699 F.2d 185 (4th Cir. 1983). Also, the standard regarding the evaluation of pain has been well-established due to extended litigation in Hyatt v. Sullivan, 899 F.2d 329 (4th Cir. 1990); see also Foster v. Heckler, 780 F.2d 1125 (4th Cir. 1986).

There are also several reasons why the reversal rate is rising. First, at least in Maryland, we feel that there is a higher reversal rate due to an increased number of individuals being represented. In Maryland, there is a program funded by the State to assist disabled public assistance clients in applying for SSI and to have representation through the appeals process. The Legal Aid Bureau is a subcontractor and represents hundreds of clients through this project annually. The project provides an increased ability to obtain medical records and provide consultative examinations if treating records are unavailable or inadequate. Although, it has come to our attention that when these consultative examinations are provided at the DDS level, they are usually ignored.

Second, ALJs are more willing to obtain consultative examinations with an accompanying RFC form, especially in mental impairment cases. Most importantly, the ALJ pays attention to those reports.

Third, there has been an increase in the number of applicants in the system while DDS continues its practice of poor documentation and failure to properly evaluate evidence. This increase in the number of applicants makes the higher reversal rate even more glaring.

In our opinion, improvements at DDS are needed on several levels: (1) they need more staff; (2) their staff needs to be better trained; (3) DDS should abandon its policy that only a DDS physician is able to make an RFC determination; and (4) DDS should not be tied to the Programs Manual and the Social Security Administration should abandon its policy of nonacquiescence.

II. WAYS TO IMPROVE THE SYSTEM BY EXPANDING INFORMATION.

A. Face-to-Face Interview.

We agree with the concept of a face-to-face interview at the initial level since it is important that the adjudicator see the claimant. DDS representatives claim that that is one of the main reasons why ALJs reverse DDS decisions. However, if there is to be a face-to-face interview at the initial level, it is important that there are enough decision-makers. Further, the face-to-face interview must be done by the decision-maker, not merely by someone who will take notes and pass them on. If the interviews are done by DDS, there are few offices in the State causing accessibility problems. For instance, in Maryland, there is only one DDS office which is located in the Baltimore Metropolitan area.

B. Documentation.

The key to a successful disability determination process is having an adequate documentation base and properly evaluating the documentation that is obtained. We have found throughout our representation that we have a high success rate even when we represent clients at reconsideration because we submit medical information that DDS did not obtain, although it is readily available. There is simply no reason for this since we often use programmed letters and forms. Another problem is that the DDS forms do not ask the questions that are relevant to the disability determination process which are addressed by form and letters we use.

Section 3 of the proposed legislation provides a sound basis for providing documentation. Our comments are as follows:

(A) Statements from Individual, Family, Lay Sources, Etc.

Statements from lay sources including the claimant are important but expecting a client to bring it in may be overly burdensome, especially for mentally ill and/or illiterate claimants whom SSA fails to assist. There is concern that these statements would be used against the claimant, perhaps by limiting the claim to the impairments described in the letter. Further, a claimant could be misguided as far as what information is needed.

This statement may not be necessary if a face-to-face interview is implemented since the same information could be

obtained at that point. Obtaining this information at an interview would provide a better and more efficient format, especially from impaired clients. For instance, the interview that we do in our own office provides adequate information regarding background, vocational history, medical impairments and functional limitations and gives us a good idea of the client's limitations. However, we recognize that performing such interviews would require increased funds for adequate staffing.

(B) Medical Records.

It is important to ensure that SSA obtains records from all sources. As discussed previously, it is unclear why we are able to obtain information that SSA does not obtain. This problem is increased by SSA's failure to assist claimants who are limited in their ability to develop their cases. Many of our clients suffer from mental disorders which make them poor historians and therefore unable to provide SSA with the necessary information regarding past medical care. In addition, many of our clients are poorly educated and are simply not aware of the information required to file a complete application.

One suggestion to alleviate poor case development due to inadequate information would be to access, where available, a claimant's Medical Assistance usage. In those states, such as Maryland, where claimants receive state-only Medical Assistance or AFDC, a system could be worked out in which Medical Assistance usage could be used to track hospitalizations as well as doctor visits. This would be done with the claimant's consent.

An additional problem is that it is possible that DDS is not able to adequately reimburse hospitals and treating sources sufficiently to obtain information and that hospitals ignore the requests.

(C) Treating Physician's Records.

This is a necessary requirement; however, SSA must use better letters and forms. As discussed earlier, general requests for information are inadequate. Office records are often very slim and usually do not address social security disability factors. Further, any request to a treating source must include a RFC assessment. We suggest that the requirements set forth in Section (D) be included for treating sources.

(D) Reports From Consultative Examinations.

This is also a necessary section, but as discussed for Section (C), the RFC and pain assessments must be obtained from treating sources. This section requires SSA to obtain them only for examinations "which have been performed by or under the Secretary." This would be inconsistent with the general rules in the Fourth Circuit regarding the weight given to reports of treating physicians and would also seriously limit the quality of evidence available.

(E) Reports by Social Workers, Etc.

This is also an important provision since treating sources other than physicians often know claimants much better than a doctor. For instance, for mentally ill clients, a non-physician therapist often does therapy and sees the claimant much more frequently than the doctor who only prescribes medication and usually performs a brief monthly examination. However, as with treating physicians, these non-physician treating sources should also provide RFC assessments given their knowledge of the claimants. There also should be a statement that any form signed by a therapist would be given the same weight as a form signed by a physician from the same treating facility.

In sum, whatever documentation SSA is required to obtain, erroneous determinations will continue to be made unless SSA pays proper attention to the evidence and evaluates it under the proper standards. Once again, SSA should be required to abandon its policy of nonacquiescence.

III. HOW TO IMPROVE TIMELINESS.

A. Eliminate Reconsideration.

The reconsideration level is presently a mere barrier to obtaining benefits. DDS fails to obtain proper documentation at that level and the reconsideration only adds to the delay. If a face-to-face interview is required at the initial level and SSA is required to obtain better documentation, the quality of the decisions will improve and we do not see the necessity for a reconsideration level.

B. Time Limits.

We are currently finding that delays at both the Administrative Law Judge and Appeals Council level are increasing. Currently, some clients are waiting for up to one year from the date of their hearing request before a hearing is held. More months pass before they receive a decision from the ALJ and, if favorable, they may wait several more months before receiving payment. If they appeal, delays at the Appeals Council level further exacerbate the problem with clients waiting from nine months to one year to receive a decision. It is thus not surprising to have a client wait at least two years from the initial application level through the Appeals Council level. Adding in another year at the federal court level, it could be up to three years before a client receives a fair and adequate determination such as one provided by the federal court. The problem with delays are exemplified by the cases of two clients on whose behalf I am testifying.

Ms. E. filed her application for DIB and SSI benefits in May, 1988. She suffers from severe depression, chronic back pain and carpal tunnel syndrome in both hands. She is currently 52 years old and last worked in 1980 as a nurse's aide. She received an ALJ denial in August 1989 and filed an appeal in the same month. It took the Appeals Council more than thirteen months to make a decision in October

1990, remanding the case to the ALJ, primarily for failing to properly evaluate the depression. A remand hearing was held in April 1991 and she is still waiting for a decision, three years after her application was filed.

Ms. W. applied for DIB and SSI in July 1987 when she was sixty years old, alleging ipairments of severe hearing loss, arthritis, asthma, hypertension, visual impairment and borderline intelligence. She had last worked in 1983. She requested a hearing before an ALJ in February 1988, had a hearing in October 1988 and received a denial in January 1989, 11 months after her hearing request. Her request for review by the Appeals Council was pending for eleven months, when a remand to the ALJ was finally issued. The ALJ issued a decision on the record nine months after that. Ms. W. only began receiving payments in January 1991, more than three and one-half years after she filed her application.

To deal with these delays, we propose that statutory time limits be implemented. In Heckler v. Day, 467 U.S. 104 (1984), the U.S. Supreme Court held that courts had no authority to impose time limits on Social Security, deferring to Congress on that point. We thus urge the Subcommittee to consider the implementation of time limits. For example, it is not unreasonable to expect a decision at the ALJ level to be made within six months from the date of the hearing request. These types of deadlines already exist in welfare cases.[2/]

We further propose that the Appeals Council have a time limit of 60 to 90 days. If no action was taken in that time, the decision would then be final and the client could appeal to federal court, much in the same way as EEOC decisions are handled.

IV. ADVISORY BOARD.

We feel that this would be a useful improvement. However, implementing improvements regarding the gathering of documentation, elimination of delays and application of correct legal standards would alleviate many of the problems currently experienced at the DDS level.

V. CONCLUSION

In conclusion, we applaud the efforts of the Subcommittee to improve the disability determination and appeals processes. Establishment of a Social Security Court will

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2/ The federal entitlement programs guarantee that hearing decisions be issued and all corrective or administrative action required by the decision be taken within a set period of time from the date of the hearing request: (1) Food Stamps: 70 days. 7 C.F.R. §273.15(c)(1); (2) Medical Assistance: 90 days. 42 C.F.R. §431.244(f); (3) AFDC: 90 days. 45 C.F.R. §205.10(a)(16).

not make the changes where they are most required -- at the beginning of the process. Increasing numbers of appeals to federal court only reflect the problems within the administrative process. In our experience, the United States District Court for the District of Maryland has made decisions in line with circuit precedent and which reflect a correct understanding of statutory and regulatory procedures. Further, the United States Court of Appeals for the Fourth Circuit, like most other federal circuit courts, has created a well-established body of legal precedent in Social Security law. Claimants have thus benefited from the generalized practice of the federal courts.

Requiring the Social Security Administration to follow circuit precedent, obtain better documentation and reduce delays will greatly improve the system. Establishment of a Social Security Court will not remedy the problems nor institute change where it is most needed, namely, at the administrative levels, particularly at the initial and reconsideration levels. These improvements, if implemented, will reduce the numbers of tragic cases like those of Ms. C. and Mr. G., serious disabled individuals who were clearly entitled to receive social security benefits but who simply could not live long enough to survive the bureaucratic process.

Chairman JACOBS. Thank you.
Ms. Samuels.

STATEMENT OF BARBARA SAMUELS, CITYWIDE COORDINATOR, DISABILITY ADVOCACY PROJECT, LEGAL SERVICES OF NEW YORK CITY

Ms. SAMUELS. I do not think I can do too much better than Ms. Zelenske has done in outlining what the problems are, and I agree with virtually everything she said.

One of the things, though, that I would emphasize, I think, is that the DDS, rather than needing more discretion, should be, in fact, applying the law as the law is stated. The principal concern that I have, or at least one of the principal concerns I have with the way the administrative process operates—and it has been mentioned today a number of times—is the difference in the standard that is used at the first level versus the standard that is used at the ALJ level and beyond.

The DDSs, however, do not have the independence to determine what standard they will apply, and I am not sure that I understand what the gentleman had in mind who spoke in the previous panel, when he asked for more discretion within the DDSs, because the DDSs are truly under the control, direction and directives of the Social Security Administration. After all, it is they who write the POM that guides what the DDS analyst can do and what they must look at.

Principally, the difference between what happens at the initial and reconsideration stages from the ALJ stage lies in what they are allowed or willing to look at, in terms of medical evidence.

As Ms. Zelenske has already said, the DDSs do not collect, and even if they had, they would ignore or discount residual functional capacity assessments by treating physicians, in favor of the medical consultants which they use, and who, without exception, write and sign off on the RFC assessments that are invariably found in claimants' files.

Now, that is a substantial difference from what happens at the ALJ level, where the administrative law judge must look at the record as a whole, including functional assessments from treating doctors.

So, we are not just talking about a problem with collecting all of the evidence. SSA, after all, at all levels has been obliged to do that for a number of years. We are saying, as well, that the problem lies in what evidence is credited at the initial and reconsideration stages, what is found relevant to the determination of disability, and that I think is where I see the major problem here.

Whether or not the reconsideration stage is eliminated, my principal concern goes to whether or not the proper legal standard is applied. If the Social Security Administration required the DDSs to apply the proper legal standard, then it seems to me that the process would streamline itself, because more claims would be adjudicated properly, not under its quality control standard, which makes very, very little sense as it is currently applied, but in whole numbers of claims that are, in fact, approved at the initial and reconsideration stages.

If the reconsideration is eliminated we still have the problem of collection of evidence. The DDSs are not doing a thorough job in collecting medical evidence, because they do not see the value, under the rules by which they operate, in seeking the sorts of medical evidence that ALJs rely on, for example, functional assessments from treating doctors, along with the other kinds of objective evidence that Social Security collects generally.

In terms of face-to-face interviews at whatever level, initial or reconsideration, the principal utility of such an interview lies in, and only in, the decisionmaker doing the interview. If somebody at Social Security who is not going to make the decision is going to do that interview, it will be about as meaningless as the claims representative's observations are, which now are found in the forms that are developed at the district offices of Social Security.

Sometimes, one finds very, very compelling statements within those forms about the limitations that the claims representative has observed, and yet they are completely ignored when the DDS analyst adjudicates the claim in another building, perhaps in another city.

So, unless the face-to-face interview is in fact performed by the person who is going to make the decision, it is going to have very little utility.

At that point, I will stop. Thank you.

[The prepared statement follows:]

COMMITTEE ON WAYS AND MEANS

SUBCOMITTEE ON SOCIAL SECURITY

HEARING ON SOCIAL SECURITY ADMINISTRATION DISABILITY DETERMINATION AND APPEALS PROCESS
May 2, 1991

STATEMENT

OF

BARBARA SAMUELS, J.D.
Citywide Coordinator
Disability Advocacy Project
Legal Services of New York City
350 Broadway
New York, New York 10013
(212) 431-7200

I have been practising law for approximately 20 years, and have specialized in Social Security and Supplemental Security Income (SSI) litigation for the last 15 years. I have done this work principally for Legal Services programs in Chicago, Illinois and, more recently, in New York City, and for a short time was a private practitioner as well. Currently I am a staff attorney with Legal Services of New York City where I am one of two citywide coordinators for the Disability Advocacy Project ("DAP"). Advocates in DAP provide advice and representation to several thousand disability claimants each year in New York City and around the State of New York. The comments which follow reflect the concerns of DAP advocates from all over New York as well as my own observations.

In the press release announcing this hearing four general areas of concern were indicated:

1. The frequency and high rate of reversal on appeal?

2. The possibility of improving the information base or the information gathering process, including the utility of face-to-face interviews at the initial application stage;

3. Methods for improving the timeliness of the decision-making process while maintaining the rights of claimants;

4. Whether advisory groups working with the Disability Determination Services (DDSs) around the country could alleviate the insularity which has been complained of as a source of decisional errors by those entities.

These comments will attempt to offer some thoughts with respect to each of these problem areas.

First, let me note, what I see as the two paramount problems confronting the adjudication of Social Security and SSI disability claims:

I. The failure of the Social Security Administration (hereafter "SSA") at the Initial and Reconsideration levels to properly apply the statutory and regulatory disability standard and in conjunction therewith its failure to consider all the evidence which must be considered in evaluating a claim for disability . The importance of this factor cannot be emphasized enough for if the standards are not properly applied nor the evidence properly considered then how can anyone wonder that these decfsions are later reversed as erroneous.

II. The failure of SSA at both the district offices and the DDS's to vigorously and persistently seek medical evidence from treating sources and to go back to those sources when the evidence received is insufficient or incomplete for adjudication purposes.

I will return to each of these problems in the discussion which follows.

I. FAILURE TO APPLY THE CORRECT STATUTORY AND REGULARITY STANDARD

Under the Social Security Act an individual is entitled to a finding of disability if he meets the statutory definition of disability. That definition requires that such individual be incapable of performing any substantial gainful activity which exists in the national economy by reason of a medically determinable physical or mental impairment which is expected to end in death or which has lasted or can be expected to last at least 12 consecutive months, taking into account the individual's age, education and work history. 42 U.S.C. 423(d)

To apply this standard SSA constructed a 5-step sequential evaluation process which is applicable in every disability adjudication. The evaluation steps in the sequence are as follows:

Step 1: Is the individual engaged in Substantial Gainful Activity? If so, they are not disabled. If not, go on to Step 2.

Step 2: Is the impairment severe? [e.g. Does it interfere with performance of basic work activities? This is a de minimis standard, Bowen v. Yuckert, 482 US 137 (1989)]. If no, claim is denied. If yes, go on to Step 3.

Step 3: Is the impairment Listed? [e.g. does an impairment meet or equal the criteria specified in one of the listings in 20 CFR 404. Subpart P, Appendix 1 which demonstrate prima facie disability. At this Step only objective medical evidence is considered]. If yes, claim is approved. If no, go on to Step 4.

Step 4: Does the impairment prevent the claimant from performing his past relevant work? (In order to make functional determinations under both Step 4 and Step 5 it is necessary to evaluate each claimant's "residual functional capacity", e.g. what they are still physically and/or mentally capable of doing despite their impairment(s)]. If no, claim is denied. If yes, go on to Step 5.

Step 5: Does the impairment prevent the claimant from performing other work in the national economy for which he is trained, skilled or educated? If no, the claim is denied. If yes, the claim is approved.

Up through the early 1980's the Social Security Administration ordered the DDS's not to go beyond Step 3 in evaluating claims at the Initial and Reconsideration levels of review. Thus, if the medical evidence in a claimant's file did not establish that they met a Listing the claim was summarily denied. [The DDS's did not ever seriously consider whether an individual's condition "equalled" a Listing, a concept which has always been, and continues to be, extremely difficult for SSA to comprehend, let alone apply.]

The Disability Reform Act of 1984, required SSA, among other things, to obtain medical evidence first from treating sources and to consider subjective complaints [e.g. pain, fatigue, weakness, etc.] Following passage of the DBRA of 1984, SSA developed an elaborate set of documents intended to rectify their failure to go beyond Step 3. These documents provided a means for DDS medical consultants to "evaluate" a claimant's residual functional capacity (RFC). These forms are still in use and are found in every claimant file.

When completed by the DDS medical consultant, the content of these RFC forms is invariably conclusory. Rarely does it specify what evidence the consultant considered, what criteria he used in comparing contradictory or conflicting evidence (or even completely uncontradictory, consistent evidence), or in drawing conclusions regarding the nature or severity of impairments. In cases where subjective symptoms (e.g. pain, weakness, fatigue, etc.) exist, it is rare indeed for any serious consideration (indeed, any consideration at all) to be evident in the RFC form.

While it is never entirely clear what the DDS's consultant bases his RFC on, it appears to be based on an ad hoc assessment of the functional significance of the results of whatever objective medical tests appear in the claimant's record, exclusive of any other evidence which a treating or consulting source might know of and find relevant to the overall assessment of the claimant's condition [such factors as subjective complaints and medical assessment of function are among the types of evidence systematically not considered by the DDS]. For example, an Initial or Reconsideration Transmittal might contain a statement like this: "Claimant's pulmonary function studies do not meet the Listing for Chronic Bronchitis. Claimant can therefore do medium work". By looking solely at objective medical test results as the basis for constructing RFC evaluations which do not take into account all the evidence of record, and by not obtaining and considering medical functional assessments from claimant's treating doctors at the Initial and Reconsideration stages, the DDS at SSA's command, is, thus, giving no more than lip service to consideration of residual functional capacity under Steps 4 and 5.

Inevitably one must conclude that the statutory and regulatory disability standard is not being applied at the first two stages of the administrative process. It is equally inevitable to conclude that this is one of the primary reasons that the reversal rate on appeal is, and has remained, so high nationwide.

II. FAILURE OF SSA TO VIGOROUSLY AND PERSISTENTLY SEEK MEDICAL EVIDENCE FROM TREATING SOURCES INCLUDING RFC EVALUATIONS.

Medical evidence is the foundation on which the disability program is based since a claimant must show the existence of a "medically determinable" physical or mental impairment to meet the first part of the definition of disability. The Disability Benefits Reform Act of 1984 commanded SSA to first obtain medical evidence from treating medical sources, and only after the failure of reasonable efforts to do so, to then seek medical evidence from consultants. In Schisler v. Bowen, 851 F.2d 43, 46 (2d Circuit, 1988), the Court explained in detail why evidence from treating sources is so important to the evaluation of disability and set forth the ways in which SSA had failed for 4 years to abide by the requirements of the Disability Benefits Reform Act of 1984, 42 USC 423(d)(5), as amended. Despite the language of DBRA 1984 and the Schisler opinion and the passage of more time, SSA continues to flaut both the letter and the spirit of the statutory requirement to seek evidence from treating sources first.

SSA's efforts to obtain medical evidence from treating sources is often desultory, at best. If a first request is not answered, a claimant may be sent for a consultant evaluation (CE) with a Social Security doctor rather than SSA making further effort to issue another request or make some other kind of contact with the treating doctor's office. If the treating doctor does submit evidence to Social Security and it is considered incomplete or insufficient for evaluation purposes, it is rare that SSA will ask the treating physician for additional information which might complete the record. Furthermore, it is unknown for SSA to pay the treating physician, as it would one of its own consultants, to perform additional tests which might be required. Nor does SSA ask the treating doctor to complete a residual functional capacity evaluation even though the treating doctor is usually in the best position to assess his patient's functional performance and limitations.

This litany of "failures" in SSA's evidence-gathering procedure is another reason why the reversal rate on appeal has remained consistently so high. It is only at the hearing stage, the point at which most claimants look for and obtain representation, that the defects in the evidence which SSA collected are remedied: that a full record is obtained from treating sources, including an RFC assessment, and that necessary testing is performed and the results submitted to SSA.

These problems in evidence-gathering are amenable to correction but only if SSA is required to do what it should have been doing for the last 6 or more years. [The fact that SSA does not enforce a policy and has not imposed procedures to comply with DBRA 1984, does not bode well for future voluntary compliance. Interestingly, in Schisler v. Bowen, SSA informed the court that SSA policy on treating physician evidence was the same as the Second Circuit rule, 851 F.2d at 45.] However, what is required is no mystery: the District Offices must obtain complete and specific information regarding all sources of medical treatment, and update this information regularly to keep it current. The District Offices and DDSs must not only initially seek medical evidence from claimant's treating physicians but must be required to go back to those sources to obtain whatever additional evidence might be needed whether the evidence exists already and was simply not forwarded initially to SSA, or whether it constitutes new testing which is necessary to fully understand the nature and severity of the claimant's impairment(s). Further, if a claimant has a treating doctor, SSA should use that treating doctor as a consultant and should pay him/her at the same rate consultants are paid. In every case in which a claimant has a treating physician the treating physician should be asked to complete a medical assessment of function (e.g. an RFC) and should be paid for the time required to do so. Finally, at the Initial and Reconsideration stages of the adjudication process the DDS must be required to apply the proper statutory and regulatory standard and to consider all evidence in conjunction therewith. For unless the proper legal standards are applied even the most assiduous evidence gathering and the most complete medical record are meaningless. (See above, Part I)

III. FACE-TO-FACE INTERVIEWS AT THE INITIAL APPLICATION STAGE

Currently, except in termination cases, the first meaningful face-to-face encounter the claimant has with SSA is held at the ALJ hearing where the decisionmaker is for the first time in the same room as the claimant. There are two reasons to hold a face-to-face interview. First, to observe the claimant. This is not meant to suggest the application of a "sit and squirm" test. However, there are things which can't be observed about people without being in the same room with them. Second, it provides an opportunity for the transmission of important information from the SSA employee to the claimant. This might include assisting the claimant to understand the concept of disability; to convey information about the defects of the medical or other evidence contained in the record and identify what additional information would be helpful.

I believe that a face-to-face encounter could be very useful as a means of expediting the decision-making process and helping to make correct decisions earlier in that process if two requirements were met:

1. Any face-to-face interview must be performed by the DDS person making the decision on the claim. If this is not the case, then any observations made by the interviewer will be ignored as certainly as such observations found in SSA questionaires and forms are currently ignored. [If DDS analysts were to perform face-to-face interviews, it would require a restructuring of the DDSs so that such person (or persons) would either be permanently housed in district offices or ride a circuit. This would automatically have an impact, probably a beneficial impact, on the insularity of the DDSs which was noted in the Committee's press release.]

2. The interviewer (and obviously the DDS generally) must be required to properly apply the correct statutory and regulatory standard as well as to consider all relevant evidence (e.g. the DDS must consider more than, as is currently the case, objective medical test results). Absent that, any observations regarding the claimant's physical or mental limitations, etc. would likely not even be perceived as a useful part of the evaluation process, and the exercise would be meaningless.

IV. WOULD A DDS ADVISORY GROUP BE WORTHWHILE?

While there is no question in my mind that the DDS is an insulated and isolated place, a hefty part of its problem lies in the fact that it is totally under the control of SSA whose rules and directives it is required to follow. An advisory group could play a useful role in identifying problems and helping the DDS to correct them. However, any actions or concerns identified by such an advisory group would have little success of improving DDS operation unless the regional offices of SSA participated as a member of each advisory group. Unless SSA participates in some way, the work of an advisory group would more likely than not be ignored and, therefore, would be meaningless.

V. PROBLEMS OF TIMELINESS AND QUESTIONS OF STREAMLINING THE ADMINISTRATIVE PROCESS.

First, I must note one personal observation. The four-tier appeal process which follows an initial application, whether designed with such intent or not, is an obstacle course whose function is to wear out applicants and thereby reduce the number of claims which reach the ALJ level, the Appeals Council and, of course, the District Courts as well. The process is not only discouraging but also time consuming. Claimants often have no understanding of how the process works, why it works that way or how to deal with it constructively.

Objectively, therefore, it might make lots of sense to reduce the number of stages in that process. The Reconsideration is more often than not a rubberstamp of the initial denial. Why waste the time? Go straight from an initial denial to an ALJ hearing. I do not think, however, that such a restructuring at the initial stages should be effected without considerable thought as to what the resultant impact might be. For example, it is conceivable that if a greater volume of undeveloped cases (as most cases are at the initial stage) arrived at the Offices of Hearings and Appeals, ALJs would be forced to give them shorter shrift then they now give just by reason of their heavier caseloads, absent a substantial increase in the size of the ALJ corps and of the support staff available to ALJs generally. With this concern in mind, I offer two alternative scenarios which might improve the adjudication process.

A. Leave the Initial and the Reconsideration levels in place but require, for the reasons stated in Part I above, that claims be adjudicated pursuant to the proper statutory and regulatory standard. If the proper standard was applied from the beginning of the process, more claims would be approved earlier in that process and the system would consequently streamline itself.

B. In the alternative, get rid of the Reconsideration review. In its absence, denied claims would go straight to the Office of Hearings and Appeals. However, rather than rush to schedule hearings, a new unit would be created within each hearing office to perform "pre-hearing development". The function of this unit would be to thoroughly review each file as it comes in to make sure that the medical record and all other necessary documentation is in the file and is up to date. Records which were not available, or examinations which needed to be done would be obtained before the hearing was scheduled. Information-gathering centrally controlled within the OHA would be likely to expedite the process. Additionally because this collection of evidence is performed immediately before a hearing is scheduled, there would be less likelihood of a stale or incomplete record coming before an ALJ.

Whether or not the reconsideration stage is gotten rid of, I do favor getting rid of the Appeals Council. My experience with the Appeals Council over the course of many years, leads me to the conclusion that it is a moribund entity, run by analysts rather than by the Appeals Council Members. Its decisions are imprecise, arbitary, erratic and often without legal or logical foundation. For the last several years, following complaints that the Appeals Council rarely reversed unfavorable decisions, the Council has been remanding cases wholesale. Rather than remanding for any meritorious reason, remands are often ordered, principally or solely, for purposes of improving the administrative record (so that the claim is more defensible by the United States Attorney if it reaches Federal Court), or to create one additional obstacle to getting the matter into federal court at all. Because justice is rarely done by the Appeals Council; because neither its decision-making procedures nor its decisions are viable, little would be lost by deleting Appeals Council review and having appeal from an ALJ decision go directly to district court. In addition, removing Appeal Council review would have the beneficial effect of making ALJs more accountable.

I appreciate the opportunity to submit these comments for the Committee's consideration.

Respectfully submitted,

Barbara Samuels

April 30, 1991

Chairman JACOBS. Thank you, Ms. Samuels.
Mr. Silver.

STATEMENT OF MEYER SILVER, PRESIDENT, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES

Mr. SILVER. Mr. Chairman, Mr. Bunning, thank you for the opportunity to testify today on improvements in the disability process.

I am the current president of the National Organization of Social Security Claimants Representatives. We are an association of some 2,500 attorneys and nonattorneys from across the country. Our members represent claimants for Social Security and supplemental security income benefits at all administrative levels and into the Federal courts. The majority of our cases involve claims based on disability.

Most of the claimants who come to lawyers do so at the administrative hearing level. Many of the cases awarded by the administrative law judges are cases that should have been awarded benefits at an earlier level. Why did this not occur?

Development of many files at the State agency level is frequently inadequate and incomplete. Often, reports from treating sources are never requested. When requests produce no response, often no followup occurs. There is often too little information in the file concerning the claimant's limitations or the requirements of the claimant's past relevant work to allow an adjudicator to make an accurate analysis of the vocational issues.

The clearest example of this are those cases where favorable decisions are made on the record, without a hearing, after the ALJ assigned to the case is provided the key reports the agency has failed to produce.

The frequently inadequate and incomplete development is due in part to a failure, in many instances, to request existing medical and other records, to obtain consultative examinations, where appropriate, and to document the vocational demands of past work.

H.R. 1799 approaches this problem in a very constructive manner. It details the types of records and other information which should be included in every file, before any eligibility determination is made. It should be clarified, however, that SSA has a responsibility to assist a claimant in obtaining the evidence necessary to document his or her claim.

Also, we are concerned that the proposed amendment appears to limit consideration of consultative examiners' reports and residual functional capacity assessments to those performed by physicians and others at SSA's request. We would urge that the phrase contained in section 3(a)(1)(D), "which have been performed by or under the Secretary," be deleted, so that, regardless of their source, all relevant evidence would be gathered and considered.

Inadequate and incomplete development is also due, in part, to the disability examiner's lack of opportunity to meet with the claimant. Such a face-to-face interview would provide a wealth of information concerning such matters as subjective complaints of pain, previously unreported medical sources and treatments. A face-to-face interview would, in many instances, give adjudicators

the information needed to decide cases favorably, thus avoiding lengthy delays and costs inherent in the appeals process.

The need for these face-to-face interviews has become especially acute over the last few years, since recent cost-cutting efforts have eliminated the in-person interview which had historically been performed at the district office, but is now done by means of phone and mail correspondence.

In those instances where a favorable decision could not be made at the initial level, we support the elimination of the reconsideration stage, and to, instead, permit a claimant to appeal directly to an administrative law judge. Since, under the bill, the file would be complete before the initial decision had been issued, there would be no reason to delay the case for a reconsideration decision. Such a streamlining of the process would be very helpful to claimants.

Better documentation of the file and a face-to-face interview with the claimant will clearly enhance the quality and accuracy of the decision at the State agency level. However, I would caution the committee on placing too much reliance on even more detailed forms being filled out accurately by claimants. I think the present phone and mail-in application process has demonstrated the very limited ability of the average lay person, especially those whose prior employment did not require the understanding and completion of written materials to clearly express their medical problems and vocational limitations.

Even if the proposed changes are implemented, I am afraid that we can expect to see that the reversal rates of the ALJs will continue at a high rate, so long as the disability standards used by the State agencies and the ALJs continue to vary.

We would enthusiastically support the establishment of DDS advisory groups, consisting of medical and legal experts, government representatives, and advocates for the disabled. There is a need for better dialogue and communication among all levels of decision-makers. I would offer the participation of our members in any such advisory groups.

In summary, we welcome the provisions for a face-to-face interview at the initial level, and for the elimination of the reconsideration stage. H.R. 1799 is an important measure to enhance the quality and timeliness of disability decisions.

Thank you.

[The prepared statement follows:]

STATEMENT OF MEYER SILVER, PRESIDENT
NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES

Mr. Chairman and members of the Subcommittee, my name is Meyer Silver. I want to thank you for this opportunity to testify today on improvements in the disability determination process. I am the current president of the National Organization of Social Security Claimants' Representatives. We are an association of some 2,500 attorneys and non-attorneys from across the country. Our members represent claimants for Social Security and Supplemental Security Income benefits at all administrative levels and into the federal courts. The majority of our cases involve claims based on disability.

Most of the claimants who come to lawyers do so at the administrative hearing level. Many of the cases awarded by Administrative Law Judges are cases that should have been awarded benefits at the earlier levels. Why didn't this occur?

Development of many files at the state agency level is frequently inadequate and incomplete. Often, reports from treating sources are never requested. When requests produce no response, often no follow-up occurs. There is often too little information in the file concerning the claimant's limitations or the requirements of the claimant's past relevant work to allow an adjudicator to make an accurate analysis of the vocational issues. The clearest example of this are those cases where favorable decisions are made on the record, without a hearing, after the ALJ assigned to the case is provided the key reports the agency has failed to produce.

The frequently inadequate and incomplete development is due in part to a failure in many instances to request existing medical and other records, to obtain consultative examinations where appropriate, and to document the vocational demands of past work. H.R. 1799 approaches this problem in a very constructive manner. It details the types of records and other information which should be included in every file before any eligibility determination is made. It should be clarified, however, that SSA has a responsibility to assist a claimant in obtaining the evidence necessary to document his or her claim. Also, we are concerned that the proposed amendment appears to limit consideration of consultative examiner's reports and residual functional capacity assessments to those performed by physicians and others at SSA's request. I would urge that the phrase contained in section 3(a)(1) subsection D "which have been performed by or under the Secretary" be deleted, so that, regardless of their source, all relevant evidence would be gathered and considered.

The inadequate and incomplete development is also due in part to the disability examiner's lack of opportunity to meet with the claimant. Such a face-to-face interview would provide a wealth of information concerning such matters as subjective complaints of pain and previously unreported medical sources, treatments, etc. A face-to-face interview would, in many instances, give adjudicators the information needed to decide cases favorably, thus avoiding the lengthy delays and costs inherent in the appeals process. The need for these face-to-face interviews has become especially acute over the last few years, since recent cost cutting efforts have eliminated the in-person interview which had historically been performed at the District Office - but is now done by means of phone and mail correspondence.

In those instances where a favorable decision could not be made at the initial level, we support the elimination of the reconsideration stage and to instead permit a claimant to appeal directly to an Administrative Law Judge. Since under the bill, the file would be complete before the initial decision had been issued, there would be no reason to delay the case for a reconsideration decision. Such a streamlining of the process would be very helpful to claimants.

Better documentation of the file and a face-to-face interview with the claimant will clearly enhance the quality and accuracy of the decision at the state agency level. However, I caution the committee on placing too much reliance on even more detailed forms being filled out accurately by claimants. I think the present telecommunication application process has demonstrated the very limited ability of the average lay person,

especially those whose prior employment did not require the understanding and completion of written materials, to clearly express their medical problems and vocational limitations.

Even if the proposed changes are implemented, I am afraid that we can expect to see that the reversal rates of the ALJs will continue at a high rate so long as the disability standards used by the state agencies and the ALJs continue to vary. We would enthusiastically support the establishment of DDS advisory groups consisting of medical and legal experts, government representatives, and advocates for the disabled. There is a need for better dialogue and communication among all levels of decision-makers. I would offer the participation of our members in any such advisory groups.

In summary, we welcome the provisions for face-to-face interviews at the initial level and for the elimination of the reconsideration stage. HR 1799 is an important measure to enhance the quality and timeliness of disability decisions.

I thank you for this opportunity to present our views and I would be please to answer any questions you may have.

Chairman JACOBS. Thank you, Mr. Silver.
Ms. Katz.

STATEMENT OF NANCY KATZ, PROJECT DIRECTOR, SSI ADVOCACY PROJECT, LEGAL ASSISTANCE FOUNDATION OF CHICAGO

Ms. KATZ. Good afternoon. My name is Nancy Katz. I am an attorney and the project director of the SSI Advocacy Project of the Legal Assistance Foundation of Chicago.

In 1987, in Illinois, in response to problems like those you have heard today of Ms. Griffin and Ms. Rangel and others who testified earlier about the problems at the initial and reconsideration stages, the State legislature required our Illinois Department of Public Aid to create an SSI Advocacy Project. The department contracted with the Legal Assistance Foundation to set up a program to provide legal representation at those two early stages of the disability determination process.

As my written remarks make clear, our project performs many of the activities mandated by H.R. 1799. These include face-to-face interviews with clients, full medical development of the record, purchasing consulting examinations, when necessary, and obtaining statements from third parties.

The high approval rate of our clients shows that thorough case development at these early stages does improve the quality of the disability determination process. In our last fiscal year, the project received favorable disability determinations for 47 percent of our clients at the initial stage, compared to 33 percent at the initial stage statewide. That is 14 percentage points higher at our project.

More striking was the success rate of our clients at the reconsideration stage. Here, over 55 percent of our clients were found disabled, compared to only 15 percent statewide. That is a 40 percentage point difference.

Although the project wins a majority of our reconsideration cases, the vast majority of clients are unrepresented at the reconsideration stage, and this stage adds only delay and discouragement for claimants. It is not quantifiable, but we are sure that, without our encouragement, many of our clients would drop out of the disability determination process, only to apply again at a later point.

H.R. 1799 provides needed restructuring by emphasizing one thorough case development and assessment process. I would like to comment on some of the specific information-gathering requirements of the bill.

The bill requires that every case contain a detailed description from the individual of his or her disability. This is a laudable goal, but experience has taught us at the SSI Project that this detailed statement, while essential, is often beyond the intellectual capacity of many of our clients.

I would encourage the subcommittee to consider a revision of this section that makes clear Social Security's responsibility to assist the claimants in providing this detailed statement. In fact, the face-to-face interview, which is also a part of the bill, could be a place where this could take place.

In addition, one thing that we find all too frequently is that the Secretary uses the absence of an impairment in the statement that appears now on the disability application as evidence to reject or discredit that impairment. We often find later, as we are helping the client, that an impairment may surface, particularly a mental impairment, but if it is not in his or her initial application, the Secretary will discredit it. We think that the Secretary should not be allowed to do that.

With respect to the face-to-face interview mandated by the bill, it is our experience that this is an essential component of a full assessment at the early stages of the disability determination process. Since many claimants have trouble articulating their limitations, these initial interviews must be open-ended and not confined solely to the information contained in the initial application for disability benefits.

I have listed in my written statement some of the kinds of information that should be collected, and once this information is collected, it should be the basis for further case development by the DDS.

H.R. 1799 also requires the Secretary to collect medical evidence from treating sources. I echo the statements that you have heard earlier today, that the opinions of the treating physician as to the capacities of the claimant is a key to the finding of disability that occurs at the administrative law judge stage, but DDSs rarely collect this evidence.

The treating physician who sees the patient on an ongoing basis is in the best position to assess the effect of the impairments on the claimant's ability to perform physical or mental tasks. Not only must this information be collected, it must be credited, unless there is some reason to reject it.

I would encourage the committee to require the DDSs to apply the law as it exists now—it is good law which is found both in Social Security regulations and in case law—on how to evaluate subjective symptoms and pain.

Thank you for your consideration.

[The prepared statement follows:]

TESTIMONY OF NANCY KATZ

SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

MAY 2, 1991

I. Introduction

Good morning. My name is Nancy Katz. I am an attorney and the Project Director of the SSI Advocacy Project of the Legal Assistance Foundation of Chicago. Before beginning my testimony, I would like to thank Chairman Jacobs and the members of the Subcommittee on Social Security for the opportunity to appear and to present my comments on the Social Security Administration's ("SSA") disability application and appeal process.

H.R. 1799, which has been introduced by Chairman Jacobs, makes significant inroads in correcting major problems with the Social Security disability application and appeal process. The SSI Advocacy Project already performs many of the case development tasks mandated by H.R. 1799 and the high approval rate for Project cases shows that thorough case development improves the quality of the disability determination process. In my remarks, I will comment on the problems with the current process and I will describe the program the State of Illinois and the Legal Assistance Foundation of Chicago have developed to assist individuals with the application and reconsideration stage of the SSA's disability determination process. I will also discuss how H.R. 1799 will improve the current procedures and I will raise some additional problems which need correction and which H.R. 1799 does not, as currently drafted, address. Finally, I will make some comments in opposition to an Article I Social Security Court.

II. Problems in the Disability Evaluation and Determination Process at the Initial and Reconsideration Stages

In Illinois, prior to the inception of the SSI Advocacy Project, most applicants for social security disability benefits were unable to secure their benefits unless and until they had appealed two adverse decisions and received an administrative law judge hearing, a procedure that frequently takes from one to two years from the date of the initial application for benefits. While they pursued their disability claims, many disabled applicants were forced to apply for state-funded general assistance benefits of $165 monthly, which provides only a bare minimum income for survival. Many disabled individuals became discouraged and did not pursue their appeals and remained on subpoverty-level assistance.

While the reasons for these delays were many, one major reason was the lack of adequate development of the disability claims by the Illinois Bureau of Disability Determination Services ("DDS") - a division of the Illinois Department of Rehabilitation Services that makes initial and reconsideration decisions for SSA. The DDS often failed to fully develop the medical evidence for claimants and, in part due to increasing budgetary problems, failed to secure consultative medical examinations for claimants who needed them. In addition, third party information sources such as family members, friends or social workers were rarely contacted and treating medical sources were not asked to provide a meaningful assessment of their patients' residual functional capacity. This was particularly devastating for the Chicago general assistance population since most received inadequate diagnosis and medical treatment for their physical and mental problems and could not, on their own, either fully develop the evidence necessary to prove disability or even articulate clearly in many cases what their physical and mental problems were.

III. The SSI Advocacy Project: A Successful Model for Careful Case Development at the Initial and Reconsideration Stages of the Disability Determination Process

In response to the problems in the social security disability determination process, in 1987, the Illinois legislature mandated the establishment by the Illinois Department of Public Aid ("IDPA") of a new advocacy program to provide legal representation for general assistance recipients who are chronically unable to work, in an effort to help them receive SSI and social security disability benefits in a timely manner. Employing an innovative approach, the state welfare agency contracted with the Legal Assistance Foundation of Chicago ("LAFC"), a grantee of the Legal Services Corporation with experience in providing high quality free legal services to the indigent, to establish an SSI Advocacy Project that would represent general assistance recipients at the initial and reconsideration stages of the disability determination process.

The SSI Advocacy Project currently is staffed by 15 paralegals, one paralegal supervisor, two attorneys and support staff. Project paralegals, who are carefully trained in social security disability rules and procedures, conduct a thorough initial interview with claimants in order to ascertain the potential bases for a determination of disability. As part of an initial interview, paralegals elicit information about their clients' education and literacy levels, vocational backgrounds, physical and mental impairments, functional limitations, and medical treatment histories. The information obtained from these initial interviews allows the paralegals to prepare plans for development of the medical and other evidence necessary to prove disability.

Project paralegals routinely request all relevant medical records from treating physicians and hospitals. In addition, paralegals send treating doctors questionnaires designed by the Project to ease the burden of report preparation. In every case, in order to ascertain information on the residual functional capacity of the claimant, the treating physician is asked to comment on the patient's capacity to perform a host of specific mental and physical work functions, such as sitting, standing, lifting and concentrating. Often, paralegals must be persistent in encouraging uncooperative sources to provide this important evidence.

When necessary, paralegals order specialized tests and obtain statements from family members, friends and other third parties. The Project has discovered that psychological testing, including intelligence testing, is beneficial to many clients. Because of the face-to-face contact with clients, Project paralegals often identify and develop evidence of previously undiagnosed or untreated problems, particularly mental impairments. In our last fiscal year, 73% of the clients approved for benefits were found disabled on the basis of a mental impairment, with mental retardation, affective disorders (primarily depression) and substance addiction disorders predominating. This is truly a client population that previously had "fallen through the cracks" of the disability determination system, since many either had not been diagnosed previously or understandably were reluctant to allege these impairments when applying for disability benefits. This client population is also the least likely to have the ability to pursue an appeal. Since DDS adjudicators never have face-to-face contact with applicants, they are unlikely to discover that applicants suffer from these impairments.

Evidence received by Project paralegals is sent to DDS for consideration. The Project has received a great deal of cooperation from our state DDS and Project paralegals and DDS adjudicators work closely together to elicit all important

information concerning Project clients. We have developed special procedures for sharing information between the Project and DDS and DDS gives Project paralegals advance notice before a decision is rendered at the reconsideration level so that paralegals can submit all remaining evidence. In addition, Project paralegals submit a written legal statement in support of their clients' claims to show why they should be found disabled under applicable social security regulations and law.

The approval rate for disability applications of Project clients attests to the success of careful case development at the initial and reconsideration stage of the disability determination process. During our last fiscal year, favorable decisions were received in 1,338, or 79% of the 1,701 decided cases closed by the Project. In addition, the approval rate for clients represented by the Project is much higher than the approval rate statewide. At the initial stage, DDS statistics show that the Project received favorable disability determinations for 47% of our clients, while the statewide rate was 33.4%. More striking is the success rate of the Project at the reconsideration stage. Here, 55.1% of our clients were found disabled compared to only 15.2% statewide.

IV. Analysis of H.R. 1799

Although the SSI Advocacy Project wins the majority of its cases at the reconsideration stage, only a small fraction of applicants for social security disability benefits in Illinois receive our services. The problems I discussed with the disability evaluation and determination process remain a barrier to benefits for the majority of applicants. It is obvious that with only a 15% approval rate both in Illinois and nationwide, the reconsideration stage of the disability determination process adds little but discouragement for disabled individuals and delays their opportunity for an administrative law judge hearing, at which they stand a real chance for a fair assessment of their disability claims. H.R. 1799 provides a needed restructuring of the disability determination process by emphasizing at the initial stage of the process thorough development and assessment of claimants' physical and mental impairments and their ability to do work-related activities. I would like to discuss some of the specific information gathering requirements in Section 3 of the bill as well as the face-to-face interview requirement of Section 2. I will also point out certain problems with the process which still need to be addressed.

A. The Detailed Description of Disability

Under H.R. 1799, Section 3 (a), the Secretary will be required in every case to have "a detailed description from the individual of his or her disability" which can include statements from a family member, friend, or employer if offered by the individual (emphasis added). While experience has taught us at the SSI Advocacy Project that this detailed statement is essential, often our clients are intellectually incapable or too disoriented to provide this information without significant assistance from Project paralegals. As it stands now, we see, all too often, a rejection by DDS of objective psychological evidence establishing claimants' mental impairments because the claimants did not allege these impairments in their disability reports. I would encourage the Subcommittee to consider a revision of this section that makes clear the Secretary's responsibility to assist claimants, particularly SSI claimants, in providing this detailed statement. As I describe below, the face-to-face interview mandated in Section 2 of the bill could be used to assist the claimant in explaining his or her impairments and consequent limitations. In addition, the Secretary should not be allowed to use the absence of an impairment in claimants' initial statements regarding their disabilities as a reason to reject or discredit evidence of that impairment.

B. Collection of Records from Medical Sources

H.R. 1799 also requires the Secretary to collect medical records from hospitals, clinics and physicians who have been treating the applicant since the alleged onset of the disability. This provision will assist in those cases where although DDS has collected good current medical evidence, a question remains as to the onset of the impairment.

I would encourage this Subcommittee, however, to require the Secretary not only to collect medical records from treating physicians, but also to establish procedures and forms to elicit information in an organized fashion from treating physicians as to the residual functional capacity of their patients. Unless a claimant's impairment meets the criteria of one of the Listing of Impairments, a residual functional capacity evaluation is critical to the determination of disability. The treating physician, who sees and treats a patient on an ongoing basis, is in the best position to assess the effect of the impairment on the claimant's ability to perform physical and mental activities.

It is critical not only that DDS collect this residual functional capacity evidence from treating sources, but that this evidence be evaluated under the proper legal standards. What makes the disability determination so difficult in many cases is that while many impairments are verifiable by objective tests or measures, their functional consequences are not. Both Social Security regulations and caselaw address this problem and dictate the proper procedures for evaluating pain and other subjective symptoms caused by impairments. For example, Social Security Ruling 88-13 provides a number of factors to consider in evaluating cases involving pain and other objective symptoms, including: 1) the nature, location, onset, duration, frequency, radiation, and intensity of pain; 2) precipitating and aggravating factors; 3) type dosage, effectiveness and adverse side-effects of medication; 4) treatment; 5) functional restrictions; and 6) the claimant's daily activities.

Despite the clear guidelines of the law and regulations, DDS fails to properly evaluate residual functional capacity evidence from treating sources even when it is made part of the record. The SSI Advocacy Project routinely collects this information; however, DDS rarely credits it. While the reviewing physicians who prepare physical residual functional capacity assessment forms for DDS are required to provide a rationale for rejecting the assessment of a treating medical source, they rarely provide an intelligible rationale for rejecting this evidence. Absent good cause for rejecting a treating physician's opinion, it should be accepted. If good cause exists, DDS reviewing physicians must be required to specify the good cause and to provide an explanation for rejecting the opinions of treating physicians that comports with the requirements of Social Security Ruling 88-13 and the decisions of the Circuit Court of Appeals in the jurisdiction.

C. Consultative Examinations

Consultative examinations often provide crucial medical information necessary to prove disability, particularly for indigent SSI applicants who often receive inadequate medical care. An x-ray, an EKG, or a pulmonary function test performed as part of a consultative examination can be a pivotal factor in a finding of disability. Unfortunately, as a result of budgetary cuts, we have seen a decline in the number of consultative examinations scheduled for our clients, to their disadvantage. H.R. 1799 requires the Secretary to include consultative examinations in the administrative record. We encourage the Subcommittee to work to maximize the budget available to DDS for consultative examinations.

D. Statements from Third Parties

H.R.1799 requires the Secretary to obtain reports by social workers, therapists, community mental health workers and other medical or vocational personnel with relevant information. The Project routinely requests this information when it is available and it can be invaluable in assessing mental and physical capacity. Often, individuals such as visiting nurses, drug abuse counselors or therapists have more ongoing contact with claimants than do treating physicians and are in the best position to assess the claimants' capacities to perform work related activities.

Family members and friends with frequent contact with claimants should also be included in the list of third party resources. There are some disorders where the reports of those in close daily contact with claimants are essential, but these reports are rarely obtained by DDS. For example, in cases where claimants allege seizure disorders, the report of witnesses to seizures are necessary for proper evaluation of the cases. In most instances, the witnesses will be family members or friends. For substance abusers as well, the reports of close personal friends and family members are essential. It is well known that alcoholism and substance addiction are characterized by a pattern of denial; despite this, DDS rarely obtains statements regarding the daily activities of claimants from known contacts of the claimants. Particularly in situations where the statements of claimants as to their conditions conflict with medical evidence, third party statements from family members and close friends should be obtained.

E. Face-to-Face Interviews

H.R. 1799 requires the Secretary to conduct a face-to-face interview with an applicant for disability benefits prior to making a decision on a claim. As mentioned above, it is our experience at the SSI Advocacy Project that face-to-face contact with our clients assists us in fully understanding the nature and extent of their physical and mental impairments and, consequently, in developing the evidence necessary to support their applications for disability benefits. A face-to-face interview with a disability adjudicator as part of the initial development of a claim, if performed properly, could provide additional information on which to base a determination of disability.

Since, as described previously, many claimants have trouble articulating their mental and physical problems, the face-to-face interview must be open-ended and not confined solely to the information contained in the initial application for disability benefits. The adjudicators must be trained in interviewing skills and should attempt to elicit the following information from claimants: literacy and education level; vocational background; physical and mental impairments; medical treatment history; relevant third party contacts; and their ability to perform specific physical and mental functions, including but not limited to their capacity to sit, stand, walk, lift, concentrate, remember instructions and deal with others in a work setting. Once this information is obtained from claimants, it should be the basis for further case development by DDS.

F. Conclusion

For the reasons stated above, H.R. 1799 will improve the disability determination and appeals process. I encourage the Subcommittee to support the bill and to strengthen it by: 1) making clear that SSA has an obligation to assist claimants in providing a detailed description of their disability; 2) requiring SSA to obtain residual functional capacity assessments from treating physicians and to evaluation them under the proper legal standards; 3) maximizing the budget available to DDS for consultative examinations; 4) requiring SSA to obtain statements from family

members and close personal friends when relevant; and 5) making face-to-face interview at the initial stage open ended fact-gathering sessions conducted by trained individuals.

V. Statement in Opposition to Article I Social Security Court

In recent years, there have been a number of legislative proposals to create an Article I Social Security Court. I would like to take this opportunity to express my opposition to these proposals.

The call for an Article I Social Security Court has come in large part due to the volume of social security cases in the federal courts. As the Report of the Disability Advisory Committee to the Commissioner of Social Security (July 25, 1989) indicates, the volume of cases has stemmed from a failure of the SSA to properly and competently adjudicate the cases at the administrative level. Passage of bills such as H.R. 1799, which seek to improve and streamline the disability determination process, could substantially reduce the number of cases brought to federal court. Improving the procedures for determining disability, which is the source of the problem, should obviate the need to create a specialized Article I Social Security Court.

In addition, the public's confidence in the social security system and the federal courts will be eroded by the proposed Article I Social Security Court. While a federal district court case challenging the denial of disability benefits by the Secretary may be a small case for the federal courts, for the average citizen, a conflict with SSA is a major case involving their ability to receive benefits which will allow them to live with a measure of dignity. Removing social security cases from the federal courts and segregating them in a separate court will send a disturbing message to the public that only large corporations or million dollar cases matter in our judicial system.

Moreover, Article III Courts and the Federal Rules of Civil Procedure provide key protections for our clients. The availability of injunctive relief and the ability to bring class actions have been invaluable in assuring the rights of applicants for disability benefits. It is unclear whether a specialized Social Security Court would have these powers or would exercise them.

There are other reasons that support the retention of the present system of judicial review of social security cases by Article III Courts. These include the desirability of having generalists review Social Security cases, the benefits of geographical access to the courts by litigants and attorneys, and the opportunity for oral hearings that the present system accords. For these reasons, I urge the Social Security Subcommittee to reject proposals for an Article I Court.

VI. Conclusion

Thank you again for the opportunity to present testimony. I would be happy to answer any questions you have either now or at a later date.

Respectfully Submitted,

Nancy Katz

NANCY KATZ, Project Director
SSI Advocacy Project
Legal Assistance Foundation of
Chicago
407 South Dearborn
Chicago, IL 60605 (312)427-5200

Chairman JACOBS. Thank you, Ms. Katz.

Mr. Bunning.

Mr. BUNNING. I would like to thank the panel for being here. I have no questions.

Chairman JACOBS. Thank you for your contribution.

The final panel of the day consists of the National Committee to Preserve Social Security and Medicare, and testifying for that organization is Mr. Max Richtman; the Health Insurance Association of America, John Roberts; and Alternative Coping Resources, Inc., Charles Romero.

Mr. Richtman, please proceed.

STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, ON BEHALF OF MARTHA McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. Mr. Chairman and members of the subcommittee, I am Max Richtman, vice president of the National Committee to Preserve Social Security and Medicare. Ms. McSteen, the president of the committee, is unable to be here today, and I appreciate the opportunity to present her statement on the need to improve the accuracy of decisions on disability claims and to streamline the agency's disability appeals process.

Mr. Chairman, with the introduction of your legislation, H.R. 1799, you have taken significant strides in addressing some of the problems involving the processing of disability claims. On behalf of nearly 5 million members, many of whom are disabled, we look forward to working with you as this bill moves through the legislative process.

Last year, SSA and State Disability Determination Services made almost 2.5 million disability decisions, and the number continues to grow. Unassigned disability cases are increasing rapidly, partially because of the need to review 237,000 Zebley childhood disability cases. Improvements to SSA and DDSs ability to handle this increasing caseload are essential.

In the recent past, serious questions have been raised about the efficiency and accuracy of claim processing. SSA and DDSs efforts must be focused on making the correct decision in the initial stage of the process, so those who are disabled under the law will not have to go through a long, drawn-out expensive appeal process.

We believe that SSA should continue to have the responsibility and accountability for maintaining a national uniform and consistent disability determination process. The improvements set forth in your bill will bring greater accuracy and fairness to the disability process.

Mr. Chairman, the National Committee agrees with you that one of the keys to accurate, timely decisions is proper development of the case. This is the responsibility of both the Social Security office and DDS. At the claimant's first appointment, the claims representative has the responsibility to explain the eligibility criteria and to instruct the claimant on how to assemble the necessary evidence. Training Social Security claims representatives and DDS examiners on interviewing techniques and developing these compre-

hensive disability cases will go a long way in avoiding delays and inaccurate denials.

Mr. Chairman, the requirement in your bill for a face-to-face interview in the early stages of the determination process is critical. The presence of the applicant can frequently demonstrate the disability more effectively than paper documents, by clarifying the ailment and adding missing information.

Greater emphasis should be placed on the development of evidence, as H.R. 1799 requires. We are encouraged by the attention your bill gives to improving case records, which results in more accurate decisions. A uniform system nationwide will help in making sure disability claimants are treated fairly, regardless of where they reside. This will also require sufficient appropriations to train and retrain SSA and DDS staff, particularly in light of funding reductions in recent years.

Likewise, we suggest that DDS medical personnel be used more consistently in explaining and clarifying evidence. We encourage SSA to examine involving DDSs even more in demonstration projects. Interviews can be conducted at local Social Security field offices or other mutually convenient facilities by an interviewer who is skilled in all facets of entitlements. In this connection, we look forward to reviewing SSA's soon to be released report on the "Personal Appearance Demonstration" project.

Under the current system, face-to-face interviews occur at the administrative law judge appeal hearing stage. According to the General Accounting Office, the judges question claimants extensively at hearings, and often conclude that claimants are more limited in their activities than disability examiners have determined. Since ALJs reverse decisions in over 60 percent of the cases, having face-to-face interviews in the initial stages should reduce the number of appeal hearings and, thus, be more efficient, as well as cost-effective.

In addition to reducing the number of appeals, these improvements would also reduce the time involved in processing disability claims, thereby eliminating the need for the current reconsideration process. With the improvements in your legislation, we would support elimination of the reconsideration stage.

Finally, DDSs should be given the same authority as the administrative law judges in obtaining consultant exams, thereby eliminating many administrative law judge appeal hearings.

In addition to the improvements incorporated in your bill, it is crucial that appropriations committees and the Department of HHS address the funding requirements necessary to improve this program.

Mr. Chairman, thank you for allowing me to present this testimony and our views on this Federal program. The National Committee is available to assist you and your subcommittee, as you consider changes and improvements in the Social Security disability program.

Thank you.

[The prepared statement follows:]

STATEMENT OF MARTHA McSTEEN, PRESIDENT
NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman, members of the Subcommittee, I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. For 39 years I served with the Social Security Administration, the last three years as acting commissioner. During that time I worked closely with the Social Security disability insurance program and the problems associated with it. I appreciate the opportunity to be here today to express the views of the National Committee to Preserve Social Security and Medicare on the need to improve the accuracy of decisions on disability claims and to streamline the agency's disability appeals process.

Mr. Chairman, with the introduction of your legislation, H.R. 1799, the Social Security Appeals Process Reform Act of 1991, you have taken significant strides in addressing some of the problems involving the processing of disability claims. The National Committee commends you for your interest and dedication in this undertaking, and on behalf of our nearly five million members, many of whom are disabled, we look forward to working with you as this bill moves through the legislative process.

Last year, the Social Security Administration and the State Disability Determination Services made almost 2.5 million disability decisions and the number continues to grow. Unassigned disability cases increased by over 94,000 in FY 1990 and are expected to rise another 220,000 in FY 1992, partially as a result of the need to review 237,000 Zebley childhood disability cases. Clearly, improvements to SSA and DDS's ability to handle this increasing caseload must be implemented.

In the recent past, serious questions have been raised about the efficiency and accuracy of claim processing. In my testimony today I will concentrate my remarks primarily on the intitial stages of the determination process as highlighted in your legislation, Mr. Chairman. As you address in your bill, it is essential for SSA and DDS's efforts be focused on making the correct decision in the initial stage of the process so those who are disabled under the law will not have to go through a long, drawn-out appeal process. Steps must be taken to relieve claimants of some of the emotional and financial hardships associated with the delays in processing disability claims.

As a former acting commissioner, I believe that the Social Security Administration should continue to have the responsibility and more importantly, the accountability, for maintaining a nationally uniform and consistent disability determination process. We see your suggested improvements to the early stages of the disability determination process as a crucial step in bringing greater accuracy and fairness to the disability process.

Mr. Chairman, the National Committee agrees with you that one of the keys to accurate, timely decisions is proper development of the case. This is the responsibility of both the local Social Security office and DDS. At the claimant's first appointment, the claims representative has the responsibility to explain disability eligibility criteria and to instruct the claimant on how to assemble the necessary evidence. Training Social Security claims representatives and DDS examiners on interviewing techniques and developing these comprehensive disability cases will go a long way in avoiding delays and inaccurate denials.

Mr. Chairman, your requirement for a face to face interview in the early stages of the determination process is critical. The presence of the applicant can frequently demonstrate their disability more effectively than paper documents. This face to face interview allows the claimant and the disability decision-maker to clarify the ailment or address any missing information. This personal approach to case development prior to a decision being made, encourages trust and cooperation among all parties.

Greater emphasis should be placed on the development of evidence as H.R. 1799 requires. We are encouraged by the attention your bill gives to improving case records because incomplete records account for the majority of inaccurate decisions. Having a uniform system nationwide with specific guidelines on the documents each disability case file must contain, will help in making sure disability claimants are treated fairly regardless of where they reside. Needed improvement in case development, however, cannot be accomplished without sufficient appropriations to train and retrain SSA and DDS staff, particularly in light of funding reductions in recent years.

Likewise, we suggest that DDS medical personnel be used more consistently in explaining and clarifying evidence. As with uniformity of information in case records nationwide, the role of the medical staff varies greatly from state to state. Requiring the DDS medical staff to evaluate the case records for completeness and accuracy will ensure that clear and concise information is available before the initial disability determination decision is made.

We encourage SSA to further explore involving DDSs even more in demonstration projects. Interviews can be conducted at local social security field offices or other mutually convenient facilities. The physical and geographical configuration is already in place in the field offices to accommodate the DDS examiner's interview. Claimants are accustomed to the location of the local office and their needs can best be addressed by an interviewer skilled in all facets of entitlements. We are hopeful that SSA is in the process of completing its report on the "Personal Appearance Demonstration" (PAD) project. We look forward to reviewing SSA's report on the effectiveness and efficiency of this approach from the perspective of the claimant as well as the agency.

Clearly, the cost of implementing this new process is evident. Under the current system, face to face interviews occur at the Administrative Law Judge (ALJ) appeal hearing stage. According to the General Accounting Office, ALJs question claimants extensively at hearings and often conclude that claimants are more limited in their activities than DDS examiners have determined (GAO/HRD 89-22). Since ALJs reverse DDS decisions in over 60 percent of the cases, having the face to face interviews in the initial stages should reduce the number of appeal hearings later and thus, be more efficient as well as cost-effective.

In addition to reducing the number of appeals, these improvements would also reduce the time involved in processing a disability claim. If a disability claim is properly developed through face to face interviews and improved case development, there is little question or doubt that it will move along at a faster pace. Examiners will be able to do their job expeditiously and accurately. This will in turn eliminate the need for the current reconsideration process. The reconsideration process has not

proven to be productive, resulting in significant time delays. Therefore, with the added improvements suggested in H.R. 1799, we would support the elimination of the reconsideration stage under the Social Security disability determination process.

As in consideration of all newly-proposed guidelines, emphasis must be given to providing comprehensive training to Social Security staff and DDS disability examiners. A face to face interview conducted by highly trained personnel who have the sensitivity, the ability and reasonable time to carefully review the record for completeness and accuracy will ensure that claimants receive the fairest possible decision. In addition, DDS should be given the same authority as ALJs in obtaining consultant exams. If DDS had this authority which is needed in order for proper decisions to be made, it would eliminate many ALJ appeal hearings.

The improvements incorporated in H.R. 1799, the Social Security Appeals Process Reform Act, will no doubt increase the accuracy of decisions on disability claims as well as streamline the process. We applaud these efforts. But at the same time, it is crucial that the Appropriations Committees and the Department of Health and Human Services address the critical funding requirements to improve the disability program and process. Without appropriate funding for staffing, training and implementation, the goal of producing a quality product for the claimant in a cost-effective manner will remain elusive.

Mr. Chairman, thank you for allowing me to present the National Committee's views on this important federal program. The National Committee is available to assist you and your Subcommittee as you consider changes and improvements in the Social Security disability program. Thank you.

Chairman JACOBS. Thank you, Mr. Richtman.
Mr. Roberts.

JOHN S. ROBERTS, VICE PRESIDENT, LONG TERM DISABILITY RISK MANAGEMENT, UNUM LIFE INSURANCE CO., PORTLAND, MAINE, ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. ROBERTS. Mr. Chairman, my name is John Roberts, and I am vice president for long term disability risk management, for UNUM Life Insurance Co., in Portland, Maine. I appear today on behalf of the Health Insurance Association of America, a trade of association of about 350 companies who write health and disability insurance.

UNUM and its subsidiaries are the Nation's leading provider of group long-term disability insurance and disability management services.

The HIAA believes that a timely, accurate Social Security disability claims adjudication process that protects the claimants' rights is of the utmost importance. We believe that the current appeal structure was designed to achieve those goals, but we believe that there are ways to improve the design and the performance of the existing system.

We propose that the SSA take the following steps to achieve the highest quality initial claim decision possible:

First, ensure adequate resources: Twice during the past year, we heard that the SSA had nearly exhausted its funds to process claims. Congress and the executive branch must work together to ensure that sufficient funds are available, particularly in light of the increased volume anticipated by the *Zebley* decision.

Likewise, State disability determination services should have sufficient staffing, funding, training and access to appropriate medical and other resources to make the most accurate claims determinations possible.

Second, explore all possible sources of medical information: Private disability insurance carriers conduct claims investigations on many claimants who have also filed with the SSA. We would like to explore ways we could work with the SSA, so that they could avail themselves of the information we gather during our investigation.

The joint claim development pilot program would serve several purposes. It would enable the SSA and private carriers to explore sharing resources, eliminating duplication of effort in scheduling consultative exams or obtaining information. It is more likely to ensure that the SSA claims file is fully documented prior to any initial decision.

Second, it would be easier, less confusing and less time consuming for claimants, physicians and others providing reports. The disability appeals process can be very confusing for those individuals who are already coping with the physical, emotional or economic impact of being disabled. Coordination between private carriers and the SSA would eliminate some confusion by reducing the requests that those providing reports receive.

Third, training: We know that providing uniform, high-quality ongoing training for claims examiners produces dramatic improvements in claims decision accuracy and consistency, and we encourage the SSA efforts to expand its nationwide training efforts.

Fourth, face-to-face interviews: We support the concept included in Chairman Jacobs' legislation, H.R. 1799, to provide face-to-face interviews for applicants prior to the initial decision. We would, however, recommend some minor changes, to ensure that the process is cost-effective and timely.

One, we would allow the claimant the option of having a face-to-face interview prior to the initial claim determination, only when it appears that the initial decision would be to deny benefits. A face-to-face interview should not be necessary where there is sufficient information to approve the claim at the initial stage.

Two, ensure that the face-to-face interview is conducted by trained claims adjudicators.

Three, examine some type of cost-effective way for State DDSs to set up a satellite interview site as close as they can to the claimants.

Four, require that prior to the interview, that the SSA provide the claimant with a list of the reports upon which the claim decision is being made. The claimant, his employer, representative or private insurance carrier could then supplement SSA data gathering efforts, to ensure that all relevant information is available prior to making the initial claim decision.

Five, explore options for processing disability claims. The 1984 Disability Amendments provided for the SSA to explore options for processing disability claims.

This may be an opportune time for the SSA to test alternatives, such as contracting out the initial claim development. Although it may cost more in the short run to improve the front-end claim determination process, in the long run it can produce considerable savings and efficiencies. Disputed initial claim determinations are the reason that the appeals process is so backlogged.

The private disability insurers who are members of the HIAA are in the business of determining disability claims.

We are happy to share our expertise with the SSA and Congress, as you seek to improve the appeals process.

Thank you for your attention.

[The prepared statement follows:]

STATEMENT OF JOHN S. ROBERTS
HEALTH INSURANCE ASSOCIATION OF AMERICA

My name is John S. Roberts, and I am Vice President for Long Term Disability Risk Management at UNUM Life Insurance Company in Portland, Maine. I appear today on behalf of the Health Insurance Association of America (HIAA), which represents 300 private health insurance companies providing health insurance for 95 million Americans. UNUM and its subsidiaries are the nation's leading provider of group long term disability insurance policies and disability management services.

The HIAA believes that a timely and accurate Social Security disability claims adjudication process that protects the rights of claimants is of utmost importance. We believe that the current appeal structure was designed to achieve those goals, but we believe there is room for improvement in the design and performance of the existing appeal system. During my testimony this morning, I will describe ways we believe Social Security's decision making and timeliness of decisions can be improved.

We propose that the Social Security Administration improve the initial determination process to achieve the highest quality claims decision possible. Among the steps that can be taken to achieve this goal are the following:

- Ensure adequate resources: Twice during the past year we saw news reports that SSA had nearly exhausted its administrative funds to process claims. Congress and the executive branch must work together to ensure that sufficient funds are available to process the volume of claims anticipated by SSA. Sufficient funding and staffing levels will be critical to ensuring that the agency is able to review the childhood disability claims necessitated by the Court's decision on the Zebley case without adversely impacting the claims processing times for new applications and periodic reviews of existing claimants.

  Likewise, State Disability Determination Services should have sufficient staffing, funding, training and access to appropriate medical and other resources to make the most accurate claims determination possible.

- Explore all possible sources of medical information: Private disability insurance carriers conduct claims investigations of many claimants who have also filed with the Social Security Administration. In fact, most private disability insurance benefit plans usually include an offset (reduction) for benefits received from Social Security, Workers Compensation, etc. Often, evidence of disability must, therefore, be provided twice -- to the private carrier and to SSA -- at some additional cost and time to the applicant. With the claimant's consent, private insurers can obtain information from SSA. This can be a lengthy process and increases SSA's workload. Private insurers may also have evidence that has not been made available to SSA and which could cause SSA to make a different decision at an earlier point, thus avoiding the more expensive appeals process.

  We have mentioned the possibility to SSA officials and would welcome the opportunity to more fully explore ways we could work together so SSA could avail themselves of information we gather during our investigations.

  A joint application/claim development pilot program that UNUM envisions would serve two primary purposes:

  1. It would enable SSA and private carriers to explore "sharing" resources, eliminate duplication of effort in scheduling consultative exams or obtaining medical and other supporting information, and is more likely to ensure the SSA claim file is fully documented prior to the initial claim decision.

  2. It would be easier, less confusing and less time consuming for the claimants, physicians and others

providing reports. The disability appeal process can be very confusing for individuals who are already trying to cope with the physical, emotional and economic impact of being disabled. Coordination between private carriers and SSA would eliminate some of this confusion by reducing the requests that claimants, physicians and other providers receive.

- Training: Many private insurance carriers have discovered that providing uniform, high quality ongoing training for examiners who initially review claims produces dramatic improvements in claim adjudication accuracy and consistency. We applaud SSA's efforts in this area but know that sufficient funds must be allocated for SSA to further develop uniform training programs that can be implemented nationwide.

- Face-to-Face Interviews: We support the concepts included in Chairman Jacobs' Social Security Appeals Process Reform legislation (HR 1799) to eliminate the reconsideration level of appeal and to provide a face-to-face interview for applicants prior to an initial claim decision. We would, however, recommend some minor modifications to the Chairman's proposal in order to ensure that the process if cost efficient and timely:

  1. Allow the claimant the option of having a face-to-face interview prior to an initial claim determination only when it appears that the initial decision will be to deny benefits. We believe a face-to-face interview should not be necessary in those instances where there is sufficient medical information available to approve the claim.

  2. Ensure that the face-to-face interview will be conducted by a trained claims adjudicator if it is to be a truly meaningful component of the claims decision process.

  3. Examine cost efficient ways to conduct the face-to-face interviews as close to the claimant as possible. Most state Disability Determination Services are centralized in one location, typically the state capitol. In my own State of Maine, a claimant would have to travel as much as five (5) hours from northern Maine to Augusta, our state capitol, to attend a face-to-face interview. SSA should work with State DDS's to set up satellite interview sites in much the same way SSA currently conducts its own periodic visits to distant locations to facilitate consumers' efforts to conduct business with or obtain information from the agency.

  4. Require that prior to the face-to-face interview, SSA provide the claimant with a list of the reports upon which the claim decision is being made and/or a list of reports the agency has been unable to obtain. Currently, the claimant does not know, until he/she receives the claim denial letter, what medical and other reports have been received by the agency. By providing this listing in the letter giving the claimant the option of having a face-to-face interview, the claimant, and if appropriate, his employer, representative and/or private insurance carrier, could then supplement SSA's data gathering efforts to ensure that all relevant information is available to SSA prior to making the initial claim decision.

- Explore options for processing disability claims: The 1984 Disability Reform Amendments provided for SSA's exploring options for processing disability claims other than their

being done by the state Disability Determination Services. Thomas L. Jacobs, a UNUM affiliate which specializes in disability management services, was the contractor which worked with SSA to develop the model Request for Proposal (RFP) for a pilot project.

The initial claim development, including obtaining appropriate medical and other reports, would be done by private contractors and would then be forwarded to the DDS for the actual claim adjudication. Given the impact of the Zebley decision and other recent court decisions, this may be an opportune time for SSA to test the alternative of "contracting out" part of its workload as a more cost-effective and timely way of processing claims.

Although it may cost more in the short run to improve the "front end" claim determination process, in the long run it can produce considerable savings and efficiencies. Disputed initial claim determinations are the reason why the appeal process, particularly at the ALJ level, become so backlogged and delayed. We believe that the steps we are proposing can improve the efficiency of the disability determination system without jeopardizing the rights of claimants.

The private disability insurers who are member companies of the HIAA are in the business of determining disability claims. We are happy to share our expertise with the Social Security Administration and with Congress as you seek to improve the appeal process.

Thank you for your attention to my testimony. I will be happy to answer any questions you may have.

Chairman JACOBS. Thank you, Mr. Roberts.
Mr. Romero.

STATEMENT OF CHARLES E. ROMERO, DIRECTOR/PRESIDENT, ALTERNATIVE COPING RESOURCES, INC., JACKSONVILLE, FLA.

Mr. ROMERO. I believe I will win favoritism with you.

First of all, I am a claimant myself, with two disabilities. I represent approximately 130 people who have claims pending with Social Security, who are going through the process, which takes any where from 6 months to 4 years.

I am also the service officer for the American Legion Post No. 88, in Florida. I worry about the DDS not accepting medical evidence within the VA file. I brought out this point with the SSA or SSI modernization program on March 13, 1991.

We believe your bill would be good for one thing, the face-to-face interviews. The initial application should be done only by hospital board certified practicing physicians within the area of the claimants submitting the application, outside of the government system. The physicians should be specialized within the claimant's field of disability. In other words, if the person is claiming lupus, the physician should know what the test requirements are, how you are going to find out if the disease is in remission, and if it can be controlled by the medication prescribed.

The other issue I would like to present would be for you to encourage Medicaid for the single adults. These gentlemen and ladies donate to this system, during their years of employment.

Under the current Federal law—single adults who do not have dependents but are given a disability status by the State are not considered for any kind of health care—Medicaid.

What is happening is, many people are facing medical abandonment. Medical abandonment means that their primary physicians have been bombarded by the paperwork from DDS or HHS, to the point that they are no longer seeing their patients who have applied for Social Security disability.

We suggest that you should either take out the adjudicating law judge step or train these gentlemen to be single-line in their decisions. I know that is a big step and a lot of people would not like it, but within the same area and within the same office, you will find three adjudicating law judges. One wants the evidence in layman's terms, one only considers medical evidence, and the other one will just totally discredit the claimant and is not interested in the evidence.

In summary, I believe that the SSA's attitude toward the claimants as was summarized by Ms. Sweeney, who wrote in her article in the National Senior Citizens Law publication of 1990, that no matter what law Congress passes to govern Social Security, Social Security is going to disregard the law. Social Security is going to do what they want when they want to. They have no regard for the human element.

I heard everyone up here testifying about money, and we are talking about human life. I see these people every day. I do this for free. We are a nonprofit organization. One of the DDS people or examiners should go out and watch somebody be put into a body-

bag. These are the people who do not have insurance to get the proper medical attention, and I think everybody's tune would change on the money aspect.

Gentlemen, I thank you for your time and I hope you have some consideration for this.

Thank you.

[The prepared statement follows:]

Charles E. Romero, Director/President
Alternative Coping Resources, Inc.
P. O. Box 5642
Jacksonville, FL 32247-5642
(904) 737-6688
May 2, 1991

Andy Jacobs, Jr., Chairman
Subcommittee on Social Security
Committee on Ways and Means
U. S. House of Representatives
1102 Longworth House Office Bldg.
Washington, D. C. 20515

Social Security Administration Disability Determination Services decisions are frequently reversed in the appeals process.

Because there are insiders (H.R.S.) and outsiders (non-institutionalized individuals), the figures (Prepared by the Social Security Administration Office of Retirement and Survivors Insurance) are misleading. They do not include the people who could not afford to continue to fight the system because they had to find other means to survive or because their situation resulted in suicide.

Face to face interviews that are made by the person taking the initial application should be done only by a Hospital Board Certified, practicing physician, within the area of the claimant submitting the application outside of the government system who is specialized in the field of disability in which the person is claiming. This way the doctor can request the necessary tests to be included in the applicant's claim for disability. Therefore when a person applies for disability they should be eligible for medicaid so they may be able to afford the necessary testing required by the physician. The testing which is done on the individual should be done on the same equipment to maintain consistency in the testing. (i.e. An EKG ordered by the initial interviewer/physician and then ordered again in the appeals process, should be done on the identical equipment because a stationary machine reads differently than a mobile machine.)

The Adjudicating Law Judge step is a total waste of time and tax money, ties up the legal process and should be dropped. There are no consistencies between the judges formats for decisions even within the same region. Public law is made for society and the individual's well being as put to work for the good of the people. But proven by the Social Security Administration's past performance, which ignores precedence, the people end up having to take the S.S.A. to court just to fullfill the laws already on the books. This causes undue heartache, suffering and suicide for the American people. The Social Security Administration demonstrates no values or ethics.

In summary, no matter what laws Congress passes or doesn't pass, the Social Security Administration will make decisions they consider necessary regarding the disability cases.

A watchdog group that is formed should consist of a Hospital Board Certified physician in the area of the claimant's disability, an R.N. or L.P.N. currently working within a hospital setting. There also should be legal experts, such as a practicing attorney of Social Security Law, and a paralegal. No government representatives should be within this group, and any advocates for the disabled should be used only as a communication link between the claimant, the S.S.A., and the watchdog group.

Chairman JACOBS. Thank you for your contribution.

Mr. Bunning.

Mr. BUNNING. No questions.

Chairman JACOBS. We appreciate your contributions to the record. Thank you very much.

That concludes the hearing.

[Whereupon, at 1:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

May 16, 1991

Mr. Robert J. Leonard
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Mr. Chairman:

The following statement is submitted for consideration in conjunction with H.R. 1799, "The Social Security Appeals Process Reform Act of 1991."

I am James F. Allsup, President of Allsup Inc. Allsup Inc. is a nationwide Social Security consulting service. We provide representational services to applicants for disability benefits under Title II of the Social Security Act.

Allsup Inc. is a group of non-attorney representatives. Our staff has been built around a core of former Social Security claims and management personnel, Disability Determination claims examiners, hearing officers and quality control personnel and specialists from the private sector's long term disability industry. We believe our blend of expertise gives us a comprehensive perspective into the problems of the Social Security disability claims process.

In the seven year history of this company, Allsup Inc. has represented over 5,000 applicants for the Title II disability benefits. We are currently representing some 3,000 cases in the claims and appeals process, nearly one percent of all the pending claims in the Social Security system. Our experience is unique to the history of the program.

Clients are referred to Allsup Inc. by Long Term Disability (LTD) group insurance carriers and by self-insured employee disability benefit programs. By bridging the gap between public and private sector programs, we have achieved successful awards of Social Security disability benefits for over 88 percent of all claimants represented.

Our success for our clients has been based on several factors. First, we provide representation through all four administrative levels of the claim and appeal process. In typical cases of attorney representation, the attorney is introduced to the process at the hearing level, after two denials (initial claim and reconsideration), confronted with a claims file which now must be refuted, overcome, for the claimant to prevail. Our involvement from day one results in an application and disability background report professionally presented to relate the claimants impairments to the entitlement prerequisites of the Act and regulations.

Second, by using private sector resources, we are able to obtain and submit medical and vocational assessments specifically oriented to the "Listings of Impairments" in the regulations. Documentation solicited by the private sector benefit adjudicators does double duty. It saves money from federal budgets, it saves time for medical providers of service, and coming from an LTD claim file, it is well formatted for use in the Social Security process.

Third, our knowledge of the two public and private sector systems allows us to efficiently integrate the two benefit programs. We believe that for the first time, we are making inroads to the integration the authors and designers of the programs envisioned. At the same time, we enjoy the role of neutral third party. We are not oriented to meeting ever tightening budget restrictions or protecting trust funds. We are not

inhibited by the insurers "bottom line" profit or loss. We are instead motivated by serving the best interests of the applicants, your constituents, in this process.

We believe that the objectives of H.R. 1799 are the correct objectives to pursue. They are objectives we have sought throughout the brief history of our service.

Improving the accuracy of the disability decisions made by the Social Security Administration will require several changes. First, the Social Security Administration must come to grips with its definition of accuracy and its measurement of quality as it relates to Disability Determination Service operations. The current systems of quality control and performance management at the Disability Determination Service is heavily weighted, from the disability examiner's standpoint, in favor of denying the claim. Far fewer denials are reviewed by quality analysts than are allowances. The skewing of review selection leads examiners down the path to denial to maintain their own performance statistics. Those statistics translate into monetary awards and career advancement.

The accuracy of decision making will also be improved by providing Disability Determination Service adjudicators more authority and more latitude in subjective analysis. The reality is that a Disability Determination Service examiner and an administrative law judge are not, in practice, playing by the same set of rules. More latitude for Disability Determination Service will mean more intensive training efforts. That will mean more monetary resources earmarked to that effort.

The improvement of claim quality can also be achieved by improving the initial application. There are two quick methods of accomplishing this. One is to expand interviewing resources at Social Security field offices. Downsizing has placed front-line claims representatives under mounting workload pressures. Growing claims loads and redelegated functions from the loss of other support staff have forced field office managers to wider utilization of "self-help," do-it-yourself applications. Claimants unfamiliar with requirements for entitlement to disability struggle with disability background reports, unaware that they may be disadvantaging themselves by understating the effect or frequency of symptoms or by overstating their physical capacity to lift or carry by just a pound or two. More federal dollars, more federal employees, will help alleviate that problem.

Another alternative is a philosophical change. Forty-five to fifty percent of the civilian labor force is covered by group long-term disability. A steadily growing portion of that group has access to private sector representation through their company benefit program. If Social Security will open the doors to private sector participation, it will free-up limited resources to help other unrepresented applicants. I can tell you from our experience and that of other companies in this new service industry, the Social Security Administration's reaction to private sector participation today runs the gamut. We receive reactions ranging from cooperation to apathy to hostility.

What is our role? With private sector dollars, we complete initial application interviews and forms previously done by Social Security claims representatives. With private sector dollars, we solicit and assemble doctors reports, hospital reports and special assessments previously done by Disability Determination Service employees with federal budget allocations. We monitor case progress and answer

inquiries for claimants previously answered by Social Security Administration teleservice center on field office personnel. A change in the philosophical environment of Social Security Administration will improve the process.

We support the medical documentation provision of H.R. 1799. We believe it can be improved by widening its scope to accept medical records and test results offered at the initiative of sources other than the Secretary.

We support the provision of H.R. 1799 for a face-to-face consultation providing it is clearly an opportunity and not a requirement. A face-to-face interview is clearly unneeded when medical documentation supports a decision of allowance. In such cases, it would be a misapplication of limited resources for Social Security or the Disability Determination Service to even extend an offer of face-to-face presentation. Such would be contradictory to the bill's objective of streamlining the process.

A face-to-face interview must be, unquestionably, at the option of the applicant. The physical stress of appearing for those with impairments of mobility or the emotional stress of confronting the government for those with psychological impairments must not be a legislated requirement.

Finally, we do not support the elimination of the reconsideration process. Elimination would remove one opportunity for applicants to present their case. Elimination would require the 10 to 15 percent who would have been allowed at a level that is 66 days (on average) to move forward into a 215 day process at hearing, and into an Office of Hearings and Appeals workload that is every bit as backlogged as are the Disability Determination Service units. Elimination of reconsideration, likewise, would not work well where the benefit sought is disability, but the issue at appeal is a technical (versus medical) matter, i.e. insured status, coverage of earnings, etc.

We believe that with these modifications, H.R. 1799 will again move forward the goal of improving the Social Security Administration disability claims process. We believe that with Congressional encouragement, Social Security Administration will restructure policies, channels of communication and authorized data interchange to take advantage of significant private sector resources that can help counterbalance the limitations of federal deficit reduction.

I thank the committee for the opportunity to submit these comments.

Respectfully,

James F. Allsup

James F. Allsup
President

JPA:mbk

STATEMENT OF AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons (AARP) submits the following comments for the record regarding the Social Security Administration (SSA) disability determination and appeal process. A re-evaluation of the process is critical given the processing delays and the potential for inaccurate decisions faced by claimants. H.R. 1799, the Disability Appeals Process Reform Act, is a step in the right direction. It offers a solution for two of the most significant problem areas in the current disability determination process--accuracy and timeliness.

Social Security Disability Insurance (SSDI) was designed to provide a base of income for people with disabilities. From the perspective of AARP members, these benefits are particularly important because older individuals are less likely to fully recover from a disability and much less likely to find employment after a disability than those who are younger.

To receive disability benefits, an individual of any age must meet a very strict definition of disability. And the determination of whether the applicant meets this definition is a complex and lengthy procedure.

Problems with the disability determination process are not new. In the 1970s and 1980s there were numerous court cases that addressed the way Social Security moved disability claimants through the system. In 1991 the Social Security Administration continues to preside over a disability system with overly long claims processing times, an enormous back-log of pending cases,[1] and high appeal and reversal rates. These problems prevent people with disabilities from being heard and receiving a correct decision in a reasonable time.

Social Security's job is difficult under any circumstances. It must both guard against paying benefits to those who do not qualify, and still pay benefits as quickly as possible to those who do. This task is particularly daunting because the agency is overworked, understaffed and underfunded.

The current system is not working as intended. With substantially increased caseloads and budget restrictions, services are being cut and every procedure, from applying for benefits to having a disability reviewed, is taking longer and longer.

In light of the growing crisis in SSDI, the agency must have immediate help with its budget and staffing needs so that the enormous case backlogs can be addressed and ultimately reduced. Then, the program must be examined in light of two goals. H.R.1799 focuses on the first--identifying problems and suggesting solutions that could significantly improve the current system. Changes such as those in H.R.1799 allow time to work toward the second and most important goal--a restructured Social Security disability system that not only provides benefits to those who cannot work but also provides strong support for those who wish to try.

I. IMMEDIATE NEEDS

A. Case Backlogs

At the end of November 1990, 392,000 initial disability claims were pending in the Disability Determination Services (DDS). (This is an increase of 30 percent over the 301,000 claims pending in 1989.) SSA estimates that by the end of FY 1992 the claims pending will have increased to 700,000--an increase of more than 80 percent. Because of the huge caseloads, and no increase in staff, time to process disability cases will double.

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[1] The backlog of disability cases pending in FY 1990 increased by 24 percent over those pending in 1989. The expected increase for 1991 is another 30 to 40 percent.

B. DDS Funding and the Budget
The DDS budget for 1988 through 1990 was held level at $750 million--a decrease in real dollars. The President has requested $4,532 million for SSA administrative expense for fiscal year 1992.

Should the request be enacted, the DDSs would receive an 8.5 percent increase in their funds and the Social Security Administration would be able to hire 760 workers to help with the increasing caseload.

C. The Priority--the People
If the Social Security Administration receives less than necessary funding, discussions about improvements to the system may be moot. Even if the agency's request for administrative expenses is fully funded, there will be serious problems in service delivery. Without the full allocation, Social Security will be unable to work with the people it should be serving.

II. DETERMINING DISABILITIES
A. The Sequential Evaluation
When an individual applies for benefits, his application is evaluated in a five step process called sequential evaluation. First, the claim must be submitted to the local Social Security office that determines whether all the non-disability eligibility factors are met and whether the claimant is engaging in substantial gainful activity (working and earning over $500 per month). It also gathers documentation of the physical evidence of disability--this documentation may include the names of and evidence from physicians and/or hospitals and clinics, treatments or tests that have been performed, the cause of the disability, and the chronology of the disability.

The Social Security office then passes the application and medical evidence on to the state (DDS) where the last four steps in the sequential evaluation take place. (For a further description of the sequential evaluation, see Appendix II.) If the DDS feels the claimant's evidence is insufficient to determine if the applicant is disabled, further evidence may be gathered. If the claimant is rejected after the sequential evaluation, that evaluation may be appealed.

B. The Appeals Process
Level 1) If the claim is rejected by the DDS, the claimant may request a reconsideration. A reconsideration is a second sequential evaluation with different people reviewing the case. Additional evidence may be submitted, but the claimant does not appear before the reviewers.[2]

Level 2) If the claim is denied after reconsideration, the claimant may appeal to be heard by an Administrative Law Judge (ALJ). The ALJ is responsible for seeing that the claimant's case file is fully developed and may request new or existing evidence through medical exams, subpoenas or other "reasonable means". The claimant may also submit new evidence for consideration by the ALJ. This is the first opportunity the claimant has for a face-to-face evaluation.

Level 3) If the ALJ denies the claim, the claimant may take his case to the Appeals Council which may overturn the ALJ's decision, concur with the ALJ's decision or remand the case to the ALJ for further consideration. This is the last possibility for an administrative appeal.

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[2] **Note: For persons already receiving disability benefits, Continuing Disability Reviews (CDR) are conducted to determine whether the disability continues. A beneficiary being reviewed is provided a face-to-face evidentiary hearing at this point.**

Level 4) If all administrative appeals fail, a claimant can take his case to the federal courts. The courts may affirm, reverse or remand the case for further consideration.

III. PROBLEMS IN THE PROCESS

A. Appeals and Reversals

At every decision point in the process, an individual may appeal for reconsideration. Of the approximately two-million disability claims filed annually, sixty percent (1,200,000) are denied after the sequential evaluation. About one-third, or 400,000, of these ask for reconsideration and about 15 percent of these are allowed (60,000). Almost 80 percent (275,000) of those who are denied after the reconsideration process request a hearing before an Administrative Law Judge. The ALJs reverse about 60 percent of the cases (165,000). Of those cases that are denied and request a review by the Appeals Council, approximately 38 percent are remanded to the ALJs for corrective action and 5 percent are allowed.

These numbers are significant because they represent time and money--both the claimant's and the agency's. While no system is perfect, these numbers also show shortcomings in providing a claimant's legal rights to a timely hearing and a correct decision.

B. Development of Evidence

In reports by the Administrative Conference, the Disability Advisory Council on Social Security and numerous other experts, the development of evidence is identified as a primary source of problems in the determination process. Decisions are made, then appealed and reversed because critical information was missing.

A witness at the May 9th, 1991 hearing before the Subcommittee on Social Security on the Social Security disability process testified about her difficulties..."[Social Security] didn't indicate what they needed from me." "...[There should be] some kind of a kit to guide people." Failure to gather evidence or use of incorrect evidence consumes valuable time. At best it is wasteful; at worst a claimant may die before the claim is properly determined.

IV. DEVELOPING SOLUTIONS

A. The Rock and the Hard Place

Everyone agrees there are problems in the current system and the problems aren't new. Most experts agree that better evidence, in general, and a face-to-face interview at the front end of the decision-making process, in particular, would be an improvement. In light of these problems, H.R. 1799 is a step in the right direction.

Unfortunately, the cost of providing face-to-face interviews for every claimant at the initial stage is prohibitive and the budget restraints are very real. The problem is how to walk the fine line between current budget realities on one side and the rights of claimants on the other.

The technical question is, what process might provide a more efficient way to identify necessary evidence for all cases, and thus not require the dollar investment of initial face-to-face reviews for every claimant? What approach could be used to determine a way to allocate limited resources to those areas requiring the most attention and still be fair and impartial?

B. A Potential Solution--the "Error-Prone Profile"

One possible solution is the "error-prone" profile. This type of profile simply describes the characteristics of an error-prone group. In the case of the appeals process, the data that describe both those cases appealed after the initial evaluation and those cases reversed by the ALJs could be employed. A model could be constructed that distinguishes evidence from the appealed and reversed claims and the supporting evidence from claims not appealed and/or not reversed. The model would organize and

catalog the characteristics that separate the two groups. (For a brief description of the "error-prone" profile, see Appendix I.)

Using this kind of a methodology can facilitate accuracy and timeliness of case evaluation by helping to:
1) determine which cases should be interviewed face-to-face at the initial level;

2) identify what types of cases need specific or specialized kinds of evidence, and define what that evidence is;

3) identify disabling conditions that imply other disabling conditions (heart disease and emphysema for example), and thus the need for further evidence; and

4) identify information generally not supplied until the ALJ level.

C. Some Practical Results of This Approach
1. Both the local SSA office and the DDS would have "profile" information[3] about certain types of cases that are likely to be denied and then reversed--for example, cases with multiple disabilities and factors such as age, education and work experience.[4] These cases could be identified at this first step in the evaluation process and referred immediately for face-to-face interviews rather than going through to an ALJ only to be reversed.[5]

2. Both the local SSA office and the DDS could be provided with tools to determine what evidence would be required in specific cases. A manual[6] of error-prone case-types could be prepared for Social Security and DDS personnel, thus increasing the probability of developing better, clearer, complete evidence at the front end of the process.

For example,

> *If the claimant is applying on the basis of--[X type of disability]--, be sure to get--[X type of evidence]--from the personal physician.
>
> *If the claimant is applying on the basis of--[X type of disability]--, be sure to ask for evidence of--[Y type of disability]--as well because-[X]--is often a dual disability.

3. Both SSA and the DDS could be provided with the tools to determine whether a case, even with the required evidence, has a high probability of being reversed at the ALJ level. The case can be recommended at that point for a face-to-face interview.

4. The claimant's personal physician could be told what evidence is necessary to complete the medical evaluation given the particular disabling condition. The physician could also be told how the evidence should be presented to be most useful.

5. The claimant could be told specifically what evidence is needed to assess his case in an accurate and timely manner. A brochure could be written describing what evidence

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[3] This could be listed in a manual or on-line.

[4] These are cases that even with complete evidence at the sequential evaluation stage are "error-prone."

[5] AARP recommends a one-year demonstration project. The project would use the "error-prone" profile on a sample of disability claimants to test for effectiveness and real cost to the system.

[6] This manual could be as simple as a notebook with tabs or as sophisticated as an on-line system at each claims representative's desk that "learns" more with each case that is entered.

claimants in general need to supply, and what evidence claimants with specific types of disabilities need to supply.

Conclusion

AARP commends the Committee for bringing this important issue before the Congress. We agree that accurate and timely decisions are the right of those who apply to Social Security for disability benefits. We agree that face-to-face interviews at an early stage in the process and more complete gathering of evidence would make a difference. And in the spirit of exchange of ideas, we have made some suggestions.

We urge that the Committee not see these recommendations as an end but rather as a beginning. The solutions offered at this hearing are only a first step toward a revised Social Security Disability Insurance program that, in addition to providing benefits to those who cannot work, helps individuals with disabilities re-enter the workforce whenever possible.

In light of the current crisis, we commend the Committee for its active support of the requested increase for Social Security administrative expenses that will help the Social Security program get its immediate problems under control.

Appendix I The Error-Prone Model How Does It Work

An error-prone model can be produced using a system that learns from its mistakes--an "expert system". It is accomplished in a two-stage process. The first develops an expert-system logic that replicates the denial of benefits after the initial sequential evaluation. It is basically a sequence of if-then questions and answers that lead to a conclusion i.e. benefits allowed or denied.

In the second stage, for each applicant who appeals after the sequential evaluation and continues through to a reversal by an ALJ, the learning aspect of the expert system can be utilized. The information from new cases can be added to the original logic based on the initial cases. The result is a new or modified if-then sequence of questions and answers.

By comparing the first and the second stage logic, it is possible to codify which questions should have been asked early in the claims process, and to identify the characteristics of claimants in cases that are most often reversed, for example age 55 and over, heart condition combined with emphysema.

Appendix II Sequential Evaluation Process

1) Is the individual unable to work and earn more than $500 a month ($700 for claimants who are blind)--called substantial gainful activity (SGA) If not....

2) the DDS examiner uses the medical evidence of record i.e. evidence put in the applicant's file at Social Security to answer the question, "Does the claimant have a severe impairment?" If the evidence is incomplete or conflicting, the examiner may ask for further evidence and may require an independent physician to perform an examination or test. The applicant must have an impairment severe enough that it is expected to result in death or last (or have lasted) up to 12 months. If so....

3) the DDS proceeds to determine, "Is the impairment so severe it meets or equals the requirements in the SSA Listing of Medical Impairments?" (These medical grounds are also based on the assumption that an individual cannot work given a particular impairment.)

If the impairment does **not** meet the medical listings....

4) the DDS asks, "Does the applicant have the functional capacity to do past relevant work?" First, the DDS tries to determine what capacity to perform work-related activities remains--called residual functional capacity (RFC).

5)Finally, the DDS determines, "Can the claimant do any other kind of work that is available in the economy?" The applicant's age, education and work experience is also considered at this point in the evaluation.

David R. Bryant
ATTORNEY AT LAW
SUITE 1625
180 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60601-2671

GENERAL PRACTICE
SOCIAL SECURITY

FAX (312) 263-3746
TELEPHONE (312) 263-3031

April 24, 1991

Andy Jacobs, Jr.
Chairman
Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth HOB
Washington, D.C. 20515

RE: SSA Disability . . . Process
H.R. 1799 (5/2/91 Hearing)

Dear Congressman Jacobs:

Your Press Release #3 identified four areas of specific concern:

Q.1. Why are decisions reversed so often and why is the rate rising?

A.1. Lack of funding to do the job properly and time constraints imposed at the State level.

Q.2. How to improve the substance and process of making a decision?

A.2. Expanding the information base would not necessarily lead to improved decisions. For example, many of my clients are requesting (or receiving) money from one or more other sources: V.A., Worker's Compensation, Personal Injury, Employer LTD benefits. Yet securing these documents may yield only more confusion since several different doctors may report different opinions on differing facts and findings (i.e., Plaintiff v. Defendant)

As to face to face interviews, this was tried in the aftermath of the 1984 SSDBRA with cessations. No study was done to verify whether the quality of decisions was "improved." It could help if the quality of the interview was improved. For example, why not videotape interviews of persons with an apparent or alleged mental dis-

order/physical skin disorder/amputee/ etc. The Administration has gotten away from face to face interviews by encouraging teleclaims. Personally, I strongly recommend to clients with bad medical problems to do as much as possible by phone/mail because of the physical inconveniences of traveling.

Q.3. How to speed up the process while remaining fair?

A.3. (a) Increase the amount paid to doctors and hospitals with a bonus paid for 10 day turnaround time on requests for information.
(b) Change the State Medical Forms to reflect relevant questions aimed at a specific area of concern (i.e., "Pain"). Make the forms uniform.
(c) Retain and pay qualified licensed doctors to review and assess the nature, extent, duration and severity of any alleged problem; with direct 3 way conversations between A/P State doctor and applicant.

Q.4. Should State Agencies (DDS) be watched and/or monitored by advisory groups?

A.4. I don't believe the problem of "insularty" is too widespread although it exists to a certain extent as a systemic problem. The Federal-State administrative structure sets up the insular/island mentality. State employees administering a federal program will always have mixed directions. If the State DDS becomes a political dumping ground for hiring unemployed English majors, there will be problems. If State and Federal fiscal constraints prevent "unnecessary" consultative examinations the decision/error rate may increase. If the Regional Audits are sloppy or incompetant, there is ample room for fraud on the system.

The shape and powers of the "Advisory Groups" would need to be examined before any support could be expected. I doubt if the Advisory Group could directly affect the accuracy of decisions.

"Accuracy" is a definition problem. Who decides whether a decision is accurate? The SSA may feel that a routine audit of sample disability claims reflects a 93% accuracy rate. Yet those same cases put on review before randomly selected ALJs may result in a 50% reversal rate. The same ALJ decisions may find a secondary reversal rate of 30% in U.S. District Court.

Within the "accuracy" concept are three basic elements.

1. Procedural - If someone does not get a notice or understand what is going on, their rights might evaporate. Are procedural errors even counted?

2. Substantive - the definition of disability and its elements are very different at different levels of decision-making. If SSA is a national program, why aren't the medical forms issued by State Agencies the same for each State? Are people in Alaska so different from people in Alabama regarding "symptoms, signs and findings" relative to an orthopedic problem? Yet each State Agency has a different Orthopedic (Spinal Disorder) Form to send to the family doctor for completion. Why? The same questions could be asked about credibility; pain; non-Listed illness (environmental, post-polio syndrome).

3. Who is the arbiter of "accurate." The Congress? The Courts? The Secretary? Outside auditors? The OIG?

In short, the definition of substantive and procedural accuracy is crucial to any fair assessment of the disability system's operation. Yet even more important is the impartiality and sophistication of the entity making the assessment. Any "advisory group" would need to address such issues in the context of a nationwide program.

I would be happy to elaborate on any points raised in this letter. My CV is available upon request. Since 1974, I have handled over 100 disability claim issues each year, in various settings, including Social Security venues.

Respectfully submitted,

David R. Bryant

DRB:paz

STATEMENT OF THE
CONSORTIUM FOR CITIZENS WITH DISABILITIES
SOCIAL SECURITY TASK FORCE

The Consortium for Citizens with Disabilities (CCD) Task Force on Social Security appreciates the Social Security Subcommittee's interest and attention to issues relating to the Social Security Administration (SSA) disability determination and appeals process.

The CCD is a working coalition comprised of consumer, advocacy, provider, and professional organizations which advocate on behalf of people of all ages with physical and mental disabilities and their families. Since 1973, the CCD has advocated for improved federal legislation, regulations, and funding which affect people with disabilities and their families. More than 70 national organizations now belong to the Consortium.

Without question, if people who are legally entitled to benefits are to receive them in a timely manner, it is critical that the procedures to determine eligibility work efficiently and accurately. As much of the testimony presented to the Subcommittee at its May 2 hearing demonstrates, far too many people wait inordinate lengths of time for accurate decisions on their claims. We are also concerned that many more people, discouraged, financially stressed, and otherwise unable to continue, fail to fully pursue their legitimate claims through the arduous appeals process and thereby lose benefits to which they are entitled.

The CCD Task Force on Social Security supports the provisions of H.R.1799, the Social Security Appeals Process Reform Act of 1991, which call for (a) providing claimants with an accessible face-to-face hearing before an initial decision is made; (b) the elimination of the "reconsideration" step; and (c) specification of the medical information to be collected before a decision is made.

To address some of the additional issues raised during the hearing, we urge the Subcommittee to consider the following:

1. Require local SSA staff to return to the practice of offering to assist people to fill out the lengthy, complicated application forms. The current practice of using self-help forms and/or telephone claims results in many errors which, undoubtedly, are passed on to the higher levels in the review process. This particularly affects people with mental impairments, minimal English literacy, or limited vision or hearing. Information requested on the forms is critical to the decision making process, including such things as names and addresses of physicians, hospitals, and clinics; dates of treatment; nature of impairments; and limitations on activities of daily living. The number of local SSA staff must be increased so that they can assist people with these forms as well as perform other necessary functions.

2. Require SSA and the DDSs to seek evidence regarding the extent and duration of pain and the claimant's residual functional capacity from the person's own treating physicians, hospitals, and clinics. While H.R.1799 requires development of such evidence from consultative examiners and other assessments performed "by or under the Secretary", we believe that this type of information may be most valuable when it comes from the treating sources who best know the claimant. Also, the use of this phrase could inadvertently limit the range of documentation required by the new procedures SSA is establishing for evaluating childhood disability. SSA and the DDSs should be required to obtain for the file reports from treating sources regarding pain and residual functional capacity.

3. Ensure that adequate funds are authorized to implement the provisions of the law and that adequate funds are available to address the serious understaffing of the program as a whole. The understaffing problems at SSA and the DDSs are not only undermining public trust in the agency, but are in danger of making the programs it administers dysfunctional. Congress must take immediate action to restore staffing to levels at which the agency can function as intended to administer the eligibility determinations and the benefits to which people are legally entitled.

In addition, we urge the Subcommittee to address the issues raised by Eileen Sweeney in her testimony regarding the actions of the DDSs in circumventing the process for making residual functional capacity evaluations (Testimony of Eileen P. Sweeney, May 2, 1991, Section 5, page 5-7). These are serious concerns and deserve serious attention to correction for the benefit of claimants harmed by these unauthorized practices.

Again, we thank the Subcommittee for addressing the important issues within the SSA disability determination and appeals process. If you have any questions on the above, or want any further information, please contact one of the undersigned co-chairs of the CCD Social Security Task Force.

Sincerely,

Martha E. Ford
Association for
Retarded Citizens
(202)785-3388

Joseph Manes
Mental Health Law
Project
(202)467-5730

ON BEHALF OF:

American Foundation for the Blind
Association for Retarded Citizens of the United States
American Association of University Affiliated Programs
Epilepsy Foundation of America
Mental Health Law Project
National Association of Private Residential Resources
National Association of Protection and Advocacy Systems
National Association of State Mental Retardation
Program Directors
National Head Injury Foundation
National Mental Health Association
Parylzed Veterans of America

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

Post Office Box 3776
Washington, DC 20007
Telephone 202-638-4634

MAY 25 REC'D

Executive Director
Joseph H. Owens

General Counsel
Jack G. Duncan

May 21, 1991

The Honorable Andy Jacobs, Jr.
Chairman, Subcommittee on Social Security
Committee on Ways and Means
1102 Longworth Office Building
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The Council of State Administrators of Vocational Rehabilitation is an organization composed of the chief administrative officers of the public rehabilitation programs in the states and territories. Thirty-five of the State Rehabilitation Agencies administer the Disability Determinations Services Program for the Social Security Administration.

We appreciate the opportunity to provide written testimony relative to the Social Security Administration Disability Determinations and Appeals Process.

We will comment on three specific issues: Why decisions are frequently reversed; How decisions can be improved; and What can be done to improve the timeliness of decisions.

1. Why Decisions Are Frequently Reversed.

Several factors contribute to the high Administrative Law Judge (ALJ) reversal rate (approximately sixty percent in 1990). We believe that the primary factors leading to ALJ reversals are:

a. A time lapse of several months between reconsideration, denial, and reversal; therefore, many impairments have become severe;

b. The ALJ's have more latitude in their decision-making. They are not bound by the program operations manual (Social Security Administration's interpretation of Federal Regulations) as are the Disability Determinations Services (DDS);

c. The ALJ's are not subjected to the same stringent review process imposed on the DDS's;

d. The ALJ's have face-to-face contact with the claimant.

Contrary to public perception, the ALJ reversal rate is not indicative of erroneous DDS decisions. The ALJ's are reviewing a different set of evidence, and they are applying different standards.

2. How Decisions Can be Improved.

We believe that having the DDS's and ALJ's use the same standards that providing face-to-face contact with claimants early in the process would increase DDS allowance rates and decrease ALJ reversal rates.

However, it should be noted that administrative costs would significantly increase by requiring face-to-face interviews or evidentiary hearings at the initial or reconsideration level. If face-to-face interviews or hearings are mandated, the DDS's must receive sufficient funds to implement this process, and the funds must be allocated in a timely manner to allow the DDS's to hire and train staff before the face-to-face interview is implemented.

3. What Can Be Done To Improve Timeliness?

In order to improve timeliness of decisions, the DDS must be funded adequately on a consistent basis. Downsizing of the DDS's has occurred progressively over the past five years, and processing times have soared. The recent release of the Contingency Fund and the Supplemental "Zebley" Appropriation will help, but sufficient funding for FY 1992 and beyond is needed in order to improve the timeliness of decisions and to maintain case processing time at an acceptable level.

Another way to improve timeliness is through the enhancement of EDP systems to improve the efficiency of DDS's. Many states are still operating without up-to-date EDP hardware and software. Lack of sufficient EDP equipment contributes to delays in case processing.

Again, we appreciate this opportunity to provide the Subcommittee with testimony.

Sincerely,

James B. Griffith
President

Joil A. Southwell
Chair, Disability Determinations
Services Committee

FRANKLIN W. KERN, LEGAL CORPORATION
GREGORY W. EVERS
ATTORNEY AT LAW
ONE VALLEY SQUARE, SUITE 1450
CHARLESTON, WEST VIRGINIA 25301

ATTORNEYS
GREGORY W. EVERS
REGINALD D. HENRY

AREA CODE (304)
343 5829 CHARLESTON
742 3772 CRAIGSVILLE

May 13, 1991

Sandra Casber Wise
Staff Director
Subcommittee on Social Security
B-316 Rayburn House Office Building
Washington, D.C. 20515

Mr. Chairman and Subcommittee Members:

I am engaged in the practice of law in the State of West Virginia and limit my practice to Social Security Disability and Workers' Compensation law. I am extremely pleased to learn of the introduction of the bill entitled "Social Security Appeals Process Reform Act of 1991". My experience has been that the current initial determination process carried out by DDS has resulted in discouraging applicants for disability benefits from pursuing their benefits under the appeal process following initial denial an dthus dropping what would ultimately be a successful claim before an Administrative Law Judge. The proposals made in the bill, if strictly adhered to and coupled with a closer following of pertinent and applicable Social Security rulings and regulations, including the current listings and vocational-medical guidelines, will result in an increase of awards to deserving claimants at the initial determination level and a shortened period of time for resolution of other applicants claims at the upper levels of the appeal process. It presently takes approximately one year for receipt of acknowledgment of a request for review of an Administrative Law Judge decision from the Appeals Council. Should a claimant feel the need to resort to the Federal Court system for further appeal it is taking nearly another year to receive a Recommended Decision from the U. S. Magistrate's office and as many as ten additional months to receive a final order from the U. S. District Court if objections are filed to the Magistrate's Recommended Decision. In the meantime, disability applicants and their family members not only continue to suffer but are denied the medical assistance they can obtain from the Medicare program.

I urge you your support of this bill.

Very truly yours,

Gregory W. Evers

BEFORE THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON SOCIAL SECURITY

STATEMENT
CONCERNING H.R. 1799

TO: ROBERT J. LEONARD, CHIEF COUNSEL
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515

This statement is submitted by Douglas L. Wilson, staff attorney for Florida Rural Legal Services, Inc., 110 S. Second Street, Immokalee, Florida 33934, on behalf of numerous clients presently affected by the conditions which the proposed legislation seeks to remedy:

In the course of representing many claimants for Social Security disability benefits, it became apparent to me that there was a predictable course in all the representations I undertook: the claimant always lost in the first two rounds of the determination process, and always won when he or she had a hearing before an administrative law judge. I realize that nationally statistics are less dramatic than that, but to this date the characterization holds true for me: none of my clients has ever won initially, and none has ever lost eventually.

I began to discuss this issue with colleagues in our Legal Services program, and with colleagues in other Legal Services programs and in the private bar. All had observed the phenomenon at first hand, and felt something should be done about it to relieve the burdens on our clients, some of whom died while waiting for benefits, and all of whom suffered greatly.

At length, a committee was formed to discuss litigation to pursue remedies sought in class actions brought in Tennessee, Ohio, Iowa and elsewhere in the last ten years. A strategy similar to those pursued in those cases is being discussed, and litigation is expected to be filed soon, in the form of a class action in Florida.

This kind of litigation is not satisfying. It takes years, typically, to litigate such a case, relief does not extend beyond the state where it is brought, and history suggests that, while some change in the numbers of favorable determinations is likely, there will still be a disturbingly high number of negative determinations by the state Disability Determinations Services agency such cases, followed as always by a number of favorable rulings by ALJs that is almost as high as ever.

Preparatory to filing our case, we thought it desirable to discuss some of the issues with DDS officials, and I took that opportunity to have a conversation with the director of the DDS serving our area. He was cordial, open and candid. He was also proud of the hard work and dedication shown by his staff, and by the high ratings that his office, and Florida generally, received under the criteria looked at by the Social Security Administration.

I asked him the general question that most troubled me: "Why do you think there is such a high number of denials by your office, and such a high number of reversals by the ALJs?"

He frankly acknowledged that both he and his staff regretted that they could not favorably rule on more people, but said they were bound by the rules and policies imposed by SSA, most notably in the Procedural Operations Manual System (POMS), which are not law but are required to be followed by DDSs and SSA offices.

In reply, I pointed out that those policies were subject to the Social Security Act and regulations, and case law interpreting them, and we talked about a number of specific problems advocates had commonly observed: failure to develop the record fully, failure to give proper weight to treating physicians, failure to consider combinations of impairments, failure to give weight to claimants' expressions of pain, and so on. Yet it seemed clear to many of us that, unless the claimant met the strict definitions of the Listings of Impairments in the regs -- which is only one way of showing entitlement to benefits, th: very hardest way -- the claimant was going to lose at the DDS level. "Isn't that true?" I asked. "What's really going on?"

After a moment, this is what he said:

"I'll tell you what is really behind that. You're right. We do only approve a case when it's in black and white, absolutely clear under the Listings.

"We do it that way because of the quality assurance system.

"To begin with, the determiners never see the claimant, so our determinations are subject to second-guessing by the next level of review, the theory being that they are equally situated to determine the question of disability. We know that if we make a determination that might not be looked on kindly from above, the people looking can be anyone in the chain all the way up to SSA headquarters in Baltimore.

"And we know that if we make a favorable determination in a case that doesn't meet a Listing, that case will have a red flag on it in quality assurance, and the reviewers will tear that file apart, believing that something wrong will fall out.

"The red flag is in the form of coding. For example, if a case meets a Listing, that is coded as A-1. But if a case only equals a Listing -- say, there is a combination impairments, none of which meets a Listing, but the combination under the rules supports a finding of disability -- that kind of case is coded B-1.

"You learn quickly that you do not want to have many B-1s on your record."

He went on to say that people either followed that system religiously, or they burned out in frustration. The people who stayed learned to be careful about things that would get the attention of the quality review people -- "red flags" -- and said there was a list of red flags that adjudicators kept handy and updated from time to time.

The result of the "red flag" guidelines meant that virtually all determinations are "black and white".

I thanked the gentleman sincerely for his remarkable candor, which gave me insight I had not previously had. I had not heard any reference to this aspect of the system as a possible motivator in the determination process.

Yet it has been immediately clear to my colleagues with whom I have shared this information that this factor alone might lie under all the arguments over whether a particular reg or POM is being properly applied in this case or that, or thousands of similar cases.

It is obvious: if the system in any significant way puts the job of the adjudicator on the line, he or she is bound to be affected by that awareness, as my reporter affirmed most emphatically. This is a contamination of the entire process. It is also unconstitutional, and it is likely that this new information will become part of our expected litigation.

Of course, this submission is but a single anecdote, and I do not expect the pending bill to be influenced on the strength of it alone. I have not had time to get any information whether this report holds true in other states.

So my purpose at this time is to urge that the Subcommittee investigate this aspect of the system as far as the facts lead.

If the picture I have drawn is more or less accurate, I then I would indeed urge that the pending bill be amended so as to prohibit SSA and the states from tying personnel evaluations to the determination outcome.

Respectfully submitted,

Douglas L. Wilson
Florida Rural Legal Services, Inc.
Post Office Box 1109
110 South Second Street
Immokalee, Florida 33934
(813) 657-3681

Franklin Pierce Law Center

Civil Practice Clinic

May 13, 1991

Committee on Ways and Means
Subcommittee on Social Security
United States House of Representatives
1102 Longworth House Building
Washington, D.C. 205515

Re: Social Security Disability

Dear Subcommittee:

I just found out that you are investigating why so many people who apply for Social Security Disability Benefits are delayed or turned down until they appeal. As a lawyer representing disabled people for 18 years before the Social Security Administration, I am delighted that you are doing this. It has long angered me that most of my clients have had to wait for a hearing to prevail to obtain the benefits that they deserve. I am currently the Director of the Civil Practice Clinic at Franklin Pierce Law Center. Students under my supervision and that of another experienced attorney represent low income people at SSA hearings. To me, the answers for your inquiry are obvious.

The system is designed to deny benefits. What do I mean by that? I mean that no one until the administrative law judge who sees the claimant and talks to the claimant has decision-making power. It is very easy to deny a piece a paper; it is very easy to deny a form. Looking at and talking to a human being and then denying them benefits requires making an honest determination about their eligibility, rather than a dehumanizing decision made by a nameless, faceless bureaucrat who does not confront the person whose life they are damaging.

There are three other reasons why the system can only be described as one designed to deny and delay benefits and to discourage eligible applicants. The first of these is that the Social Security Administration does not seek out the relevant information. Doctors are not sent (generally and never until recently) any kinds of forms to acquire the relevant information on limitations on standing, sitting, pulling, walking, etc.. Doctors are not sent any kind of form to evaluate whether or not an impairment meets or equals a listing. Why the heck do you have a system not designed to get the proper information?

2 White Street • Concord, NH 03301 • 603-225-3450

Secondly, it never ceases to amaze me that taxpayers spend good money on non-examining physicians, who apparently see their role as denying benefits unless there is indisputable proof of eligibility.

And finally, as I indicated before, since the information gathering process is not designed to gather the information to prove eligibility, it is easy for the non-examining physicians or the persons deciding applications and reconsiderations to conclude that a claimant can sit for 4 hours at a time when there is no information to the contrary because no one has asked the treating physician for the right information. Never in my experience has a non-examining physician asked for more information; once in a great while, one of the bureaucrats may request more information, but that is rare. That is amazing to me, especially given that ALJ's frequently see the need for psychiatric exams or for further testing.

I should also add that as far as I know there are no timelines or guidelines for processing of cases; therefore, cases linger and people have their lives put on hold for too long of time.

I thank you for the opportunity to rant and rave about something that I have long believed deserves ranting and raving.

It would be rather simple to cure the weaknesses in the system by;

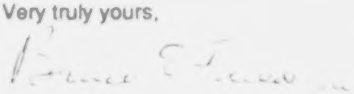
1. having earlier in the process a decision maker who sees and talks to the claimant;

2. appropriate forms that ask treating physicians not just for a slew of records but for a detailed evaluation of a claimant's residual functional capacity and that ask the physicians whether or not the impairments meet or equal the listings;

3. a system with time limits for processing cases.

One afterthought is that many of my clients are eligible because of (a) a combination of impairments and/or (b) pain and/or (c) mental illnesses that are undiagnosed. Particular attention in the process should be paid to evaluating these factors, as currently they are so grossly underevaluated. Please feel free to contact me if you want any further information. My students and I are not such good lawyers that we should win at least 80% of our cases. The problem is a system designed to deny benefits until the ALJ stage.

Very truly yours,



Bruce E. Friedman

LAW OFFICES

HARLAN, HARLAN, STILL & BILL
311 NORTH TENTH STREET
POST OFFICE BOX 933
COLUMBIA, MISSOURI 65205
(314) 874-2402
(314) 443-3354 FAX

TIMOTHY C. HARLAN
RUSSELL C. STILL
KAREN KRAUS BILL

LANE L. HARLAN
(1920-1988)
VON ALLAN CARLISLE
OF COUNSEL

May 7, 1991

Mr. Robert J. Leonard, Chief Counsel
Committee on Ways and Means
1102 Longworth House Office Bldg
Washington, D.C. 20515

Re: Hearings, May 2, 1991
Social Security Disability

Dear Mr. Leonard:

Please accept this letter as my written testimony in regard to the above hearings. I would like to share a few thoughts in response to some of the questions. My practice is limited to Social Security disability claims.

1. The Reconsideration stage should be eliminated. It is an absolute duplication of the initial level and serves only to waste tax-payer money and discourage claimants. My two favorite decisions were:

A. A claimant who had been hospitalized in a state mental hospital for two years and was told that he would not be sick for 12 consecutive months.

B. A claimant whose neurologist had written a 2 page letter and stated that she couldn't lift a cup of coffee was denied because she could lift 50 pounds--based on his letter!

2. Through either legislation or regulation (there is some argument as to which), SSA does not allow the State Agency decision-makers to really use vocational factors or the Grids. Thus a 61 year-old with a 5th grade education is often denied--and would clearly be approved on the basis of the Grids.

3. Administrative Law Judges simply do not follow the law. I cite a few personal experiences:

A. An ALJ told me that he never approved applicants from a state mental hospital because, "They are getting 3 meals a day already."

B. An ALJ refuses to ever use a vocational expert. "If I believe the claimant I'll put him on, if not I won't."

C. An ALJ refused to allow a claimant to testify at the hearing. When I submited a brief showing that he was clearly in error he wrote a decision that didn't even mention the issue!

D. An ALJ who responded to my question with: "That's a legal argument, you'd better talk to the staff attorney."

E. ALJ's who smoke during the hearings.

F. An ALJ who gives "great weight" to the opinion of the non-examining physicians of the State Agency while giving "little weight" to the opinion of the treating physician--when the caselaw is overwhelmingly the opposite.

I frequently meet with lawyers from other parts of the country who tell me the same stories--the bad ones aren't limited to Missouri. I think a friend at Social Security put it best: "We want judges to be independent, but do we want **these** people to be independent?"

I believe that if EAJA applied to the Administrative hearing level I would be looking for something else to do. If the government had to pay my fee they would not drag these out and torture these poor people. I hope that your hearings have produced some answers.

I do not submit this letter for printing. I can be reached at the above address and telephone number.

Sincerely,

Timothy C. Harlan

Statement of the Honorable William J. Hughes, Chairman
Subcommittee on Retirement Income and Employment
Select Committee on Aging

Before the Subcommittee on Social Security
Committee on Ways and Means

Hearing on the Social Security Administration
Disability Determination and Appeals Process

Thursday, May 2, 1991

Chairman Jacobs, I commend you for holding this important hearing on the Social Security disability determination and appeals process, and for introducing H.R. 1799, the Disability Appeals Process Reform Act of 1991. The bill contains a number of significant remedies for improving this process, and I believe you are particularly on target in your efforts to address the rising reversal rates at the Administrative Law Judge (ALJ) level by requiring earlier face-to-face interviews between applicants and those who are reviewing the applications.

Hearings before the Subcommittee on Retirement Income and Employment have revealed the serious backlogs in disability casework, as well as the fact that last year in more then three out of five of the cases, the ALJ reversed the original decision. Mr. Chairman, this situation is unacceptable. Too many disabled Americans and their families are having to wait over half a year to a year or more to get their benefits. Far too often, these delays cause serious hardships and place the individuals at risk of further health hazards.

I realize this is a complex matter that is not going to be solved easily or without sufficient resources to administer the disability program in a humane and cost-effective manner. I believe the personnel at the Social Security Administration and the State Disability Determination Service offices are trying to do the best job they can within the constraints of the present system and the lack of appropriate resources. But the weight of the failures within the disability system are falling on the shoulders of those who are most in need of assistance - disabled and older Americans and their families. The present system is simply not working properly.

I agree with your position that one of the major factors contributing to the high reversal rate at the ALJ level is the fact that in most cases the personnel who are reviewing the casework do not have the opportunity for a face-to-face interview with the applicant. I believe the policy should be changed so that every disability claimant is provided an initial face-to-face interview.

If the decision is made to require earlier face-to-face interviews, I believe careful consideration should be given regarding the proper setting for these interviews. Presently there are approximately 1300 field offices and more than 1700 contact stations and resident stations throughout the country. By contrast, there are around 100 State Disability Determination Service (DDS) offices.

If the initial interviews are conducted in the state DDS offices, we must keep in mind the problems which would be inherent with a system requiring disabled applicants to travel to and from the offices. In many cases, the state office would be hours away, and transportation expenses fairly significant.

On the other hand, with approximately 3,000 Social Security field offices and contact stations, the proximity to local communities would provide disabled individuals with greater accessibility to the system. While there would be the need for some additional training for appropriate personnel in the field offices, experienced claims representatives could help make an accurate judgement on whether or not the claimant is disabled, and help screen the types of cases which need to be sent on to the state DDS offices for further review. In addition, the claims representatives could play a more significant role in assisting applicants obtain the necessary medical evidence of record.

While this concept will require some further development and additional resources to implement, perhaps it could be started out on a smaller, pilot demonstration project basis.

Once again, Mr. Chairman, I commend you for your efforts to improve the disability determination and review process. At the present time I do not believe it is working, and I am greatly concerned by the added strain to the system which will result from the casework arising from the "Zebley" Supreme Court decision. Too many of our most vulnerable citizens and their families rely on the Social Security disability process. We have a moral obligation to make sure that it works in a timely and efficient manner.

STATEMENT OF COMMISSIONER ELMER C. BARTELS
MASSACHUSETTS REHABILITATION COMMISSION
CONCERNING
HR 1799 THE DISABILITY APPEALS PROCESS REFORM ACT OF 1991
MAY 14, 1991

HR 1799, The Disability Appeals Process Reform Act of 1991, is an effort to address some real concerns about the efficiency and effectiveness of the disability determination process and its impact on the lives of individuals with disabilities. The proposed legislation would require face-to-face contact at an earlier stage in the disability determination process than is now the case and would require increased efforts by the Social Security District Offices to develop more comprehensive information about the claimant's condition and functional capacities by working directly with the individual who seeks disability benefits. The goal of this proposed legislation is to decrease appeals and delays in the process and result in more accurate, earlier decisions.

Questions raised by Chairman Jacobs about the disability determination process asked for comments on several issues:

1. Can SSA decision making be improved by expanding the information on which decisions are based? If so, what additional information should be gathered?

SSA has recently solicited DDS recommendations for a supplemental interview form for workers in the district offices to gather information on activities of daily living that should help strengthen the disability decision making process. The Field Office Disability Quality Improvement directives issued in March, 1991 contain some positive procedures that should help improve information used by the DDS units in evaluating claims.

The initial intake role of the Social Security District Office where claimants may meet a staff worker face-to-face is important. The SSA intake worker is supposed to get an outline of information about medical sources and treatments which will be used by the DDS. However, short staffing of District Offices, particularly in recent years, has also been a problem. This situation has limited the capacity at initial intake to get accurate information about medical records, treating sources that gives the DDS units a good basis for gathering and reviewing medical evidence. There is a need for ongoing SSA staff training and supervision to assure that claimants receive and provide accurate information related to the disability determination process.

2. Would a face-to-face interview before an initial decision improve the quality of the decision?

esponsibilities for application and claims review process for ocial Security Benefits are somewhat fragmented among SSA istrict Offices, the Disability Determination units, and the dministrative Law Judges. Most individuals now see a staff erson at a local SSA district office when they apply for isability benefits. However, staff shortages and diffuse esponsibilities of SSA District Office staff for a multiplicity f programs and functions tends to limit the impact of this ontact so that valuable information about functional limitations hat might impact the disability determination decision is lost.

irect practical information about the claimant's functional apacities from an interview in a face-to-face setting would ertainly give the DDS examiner a better sense of the claimant's mpairments as they relate to his/her functional capacity to work nd be useful in the disability determination decision making rocess. In addition, the opportunity for the disability xaminer to integrate the information gained from such a face to ace contact with the medical information on record should ogically lead to a disability determination report that closely eflects the functional limitations and strengths of the claimant t the time of initial application.

he possibility of substituting for reconsideration a face-to-face interview with a DDS disability examiner is not a new issue. t was discussed in June, 1983 at a hearing before the ubcommittee on Social Security of the Committee on Ways and eans of the House of Representatives. Mr. Wilbur Cohen, former ecretary of Health and Human Services, and Mr. William Driver, former Social Security Commissioner, testified about this issue nd noted that it had been proposed many years previously as a ue process improvement. No consensus was reached about whether SA or the DDS units should be responsible for such contact. ravel and geographic issues, as well as costs would have to be orked out, with ample time for planning the implementation ogistics in order to result in any improvement in the process. [Hearing before the Subcommittee on Social Security of the Committee on Ways and Means of the House of Representatives, 98th Congress, First Session, June 30, 1983, Serial 98-25, pp. 89-117.] We would urge that if the Subcommittee favors a substitution of a face to face meeting for the reconsideration process in all claims, that sufficient budgetary resources and planning time be allocated to ensure that the new process is implemented properly.

3. What can be done to improve the timeliness of SSA decisions?

Gathering the information necessary to do an accurate paper review is time consuming and difficult, especially with the current very high workloads that DDS units all over the country are now experiencing. Massachusetts experienced a 20% increase in workload and a 30% decrease in staffing between 1986 and 1990. The DDS was staffed to receive 48,837 cases in FY 1990, but actually received over 55,000 cases. A similar trend has continued in FY 1991. This has led to backlogs of over 4000 cases in Massachusetts. Other states have had similar experiences. Although additional staffing has begun to help work the backlog down, applications are increasing and there are special workloads that require attention. The new "Zebly" standards for evaluating disability in children will require readjudication of applications for benefits for a projected workload of between 5000 and 10,000 cases in Massachusetts during FY 1991. In addition the standards for the Zebly cases require detailed procedures that involve considerable time and effort to achieve accurate results.

Despite the backlogs and new work standards, SSA expectations for case processing times were not altered in the regulations recently published in the Federal Register on March 14, 1991. In fact the SSA responded negatively to a comment that questioned whether the case processing times were realistic in view of many program changes resulting from judicial interpretation of eligibility standards. SSA appeared to acknowledge that no state DDS units were currently meeting the time standards, but reaffirmed them anyway. [56 FR 11616]

To make good on the timeliness standards, state disability determination units require more than regulations. They require adequate personnel resources and support, with enough lead time to staff up and train new disability examiners in the intricacies of SSA rules and procedures. By way of example, the Massachusetts DDS received SSA approval to hire 23 additional staff in September 1990. The impact of their hiring was not immediate. Although their training period was completed by mid November when they began reviewing claims, the effects of a five week case processing backlog persisted throughout FY 1990 and into 1991. In fact, there is still a backlog of about 220 claims today.

4. Why are SSA disability determination so frequently reversed on appeal? Why is the reversal rate rising?

The contention that the work of the state Disability Determination units is "inaccurate," because the Administrative Law Judges "reverse" DDS disability findings has been a persistent criticism of the disability determination program, based on misunderstanding of the multi-step process. We would agree that there are differences in the DDS and ALJ outcomes, but would attribute those differences in large part to the structure of the disability adjudication process itself, rather than to "inaccuracies" or "reversals." Federal ALJs and state workers at different stages of the process are operating with different information about the individual who has applied for benefits. They make disability determination decisions based on the information available to them and the regulations and guidelines that govern their particular part of the process. Naturally there are different decisional outcomes.

The adjudicatory process in the DDS is primarily a paper gathering review; the DDS worker seldom sees a claimant. Most information used in the claims review process at the DDS is obtained by telephone and through the mail. The DDS worker contacts treating sources to gather medical evidence and works with a physician to review that information against the SSA regulations to determine whether the claimant meets the criteria for disability. Development of additional medical evidence through purchased consultative medical examinations is undertaken if necessary to obtain sufficient information to evaluate the disability claim. Calls may also be made to family members or appropriate others to gain information about the claimant's functional capabilities in terms of his/her capacity to work.

The criticism of DDS "inaccuracy" in comparison to ALJ decisions assumes that the information available to an ALJ is the same as the information on which the DDS disability finding was made. This is not the case. Actually, the ALJ performs a *denovo* review of the case, using the medical information and evidence developed by the DDS without any representative of the DDS present to explain their determination, and any relevant new information which the claimant and the claimant's advocates choose to present. In addition, because the ALJ hears the case at least 3 months after the DDS determination was made, the claimant's condition may have changed. The claimant's physical situation and capabilities may be obvious to the ALJ through direct face-to-face observation. The process at the DDS is not staffed or funded to permit face-to-face contact with the claimant, so the DDS disability determination is made on the basis of paper evidence only.

5. Would the establishment of local DDS advisory groups improve the accuracy of decisions?

Our DDS Advisory Council has been an extremely positive force in giving us early feedback about problematic case development and working on options to improve the disability determination process. Our Council was organized in 1984. Membership includes current and former claimants, legal advocates, representatives of other state agencies that provide services to individuals with disabilities, such as the Public Health Children's Services unit. DDS staff and consulting physicians are available to meet with the Council when they have information that is relevant to the agenda. The Council meets at least quarterly. A cooperative relationship helps the DDS maintain quality decisions, through Council feedback on DDS performance in reviewing claims related to particular disabilities or groups of applicants, such as homeless persons. Among the many productive contributions to quality decisions made by our Advisory Council have been cooperative studies and recommendations about methods for evaluating particular disabilities, including post polio syndrome, chronic fatigue, and HIV+ infections and symptoms in women.

State feedback from constituents and advisory councils may sometimes lead to state challenges of SSA procedures and guidelines. Recent amendments to the regulations that govern the relationship between SSA and state DDS units suggest that local initiatives are not welcomed by SSA. In fact the March, 1991 amendments increased the level of federal scrutiny over state program and strengthened SSA noncompliance and standards permitting takeover of state DDS units. The regulatory explanation stated that:

> "...a clear and serious deficiency may eventually lead to a State agency's requiring mandatory performance support, for example where a State adopts a medical review procedure for a class of cases that clearly delays processing the cases and imposes evaluation standards which are inconsistent with our regulations or written guidelines..." [56 FR 11013]

The example of state noncompliance cited in the regulatory amendments actually involves the CDR medical improvement standard which was initially developed by the Massachusetts DDS without SSA support. This state initiative arose in response to a class action lawsuit which challenged SSA "nonacquiescence" in following First Circuit standards for CDR cases. Although improved SSA practices in appealing or following circuit precedents may minimize the potential for state-federal conflict in this process, stronger federal scrutiny of state DDS units has not always benefitted claimants or has it led to efficient adjudication of claims.

May 13, 1991

Dave Mellinger
2844 E Swiss Oaks
Sandy, Ut 84093
(801) 524-6442

Robert J. Leonard
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Leonard:

In regards to your request for written statements regarding inaccuracies and delays in SSA decision-making, I'll like to submit the following.

For the past 15 years of have been an employee of the Social Security Administration. I have worked 12 years as a claims representative and for the past three years I have been an operations supervisor. The comments that follow are solely my own observations and are not necessary those of the agency.

I believe the that high rate of reversal at the ALJ level is due primarily to the fact that the ALJs are much too liberal in their interpretation of the law and regulations regarding disability entitlement. It has been my experience over the past 15 years that their decisions are often contrary to what a reasonable person would have concluded. There have been many instances in which I thought a claimant was unmotivated and sought disability benefits in order to have a means of support, and that this would have been obvious to the judge. I would later find out that the person had been awarded disability benefits. Frankly, if someone alleges "stress" or some other mental impairment, there appears to be few cases that are denied at the hearing level. I have had attorneys that specialize in Social Security appeals tell me that they themselves do not believe all the claimants they represent are disabled, but they are in fact able to get these persons benefits.

I do not believe the problem with the high rate of reversal lies with the DDSs, but rather with the decision-making process at the ALJ level. I suggest that members of the subcommittee contact employees in Social Security offices to obtain their opinions. Frankly many of us have been dismayed for years over the reversals that have taken place on what appears to us to be spurious evidence.

In regards to the time delays in decision-making, I would like to point out that there has been a 20% cut in staff in the agency over the past five years.

Sincerely,

Dave Mellinger

SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS

HEARING ON THE SOCIAL SECURITY
ADMINISTRATION (SSA) DISABILITY
DETERMINATION AND APPEALS PROCESS

PUBLIC HEARING: MAY 2, 1991
CHAIRMAN, HONORABLE ANDREW JACOBS, JR. (D. IND.)

RE: SOCIAL SECURITY APPEALS PROCESS REFORM ACT OF 1991

COMMENTS SUBMITTED BY: RUDOLPH N. PATTERSON
WESTMORELAND, PATTERSON & MOSELEY
ATTORNEYS AT LAW
P O BOX 1797
MACON, GA 31297-4199
(912) 745-1651

Mr. Chairman, I am Rudolph N. Patterson, private attorney from Macon, Georgia. I have been in active practice since December, 1962. Our practice is what is referred to as a "people's practice." We represent people, not corporations. We are advocates for the rights of the individual. I have served my local bar, state bar, and the national bar. As a Past President and current Executive Committee member of the National Organization of Social Security Representatives, I am in almost daily contact with attorneys and non-attorney representatives of Social Security claimants from all parts of this great country.

Therefore, my comments, while they are my own, are based on my own experiences and the experiences of others in my office and throughout the United States.

Your bill addresses the growing problem of insuring quick and accurate decisions on applications for Social Security disability insurance. It suggests making three changes to decrease the growing backlog and severe hardship for disabled claimants in the process. You propose three changes:

(1) Requirement for face to face hearing;

(2) Elimination of the process of reconsideration; and

(3) Collection of medical information by the Social Security Administration.

In the background summary, you suggested that part of the problem with gathering information has been the decline in the quality of DDSs' case development in recent years so that crucial medical evidence is sometimes missing from the case folder. You state further that inadequate DDS case development leads to more and more appeals, producing a large backlog at the ALJ level and creating severe hardship for disabled claimants.

I feel your remarks are right on target with one of the major areas of problems that we are experiencing in the handling of Social Security disability claims.

As I have explained to my clients if the process worked as it should, there would be no reason to hire a representative. The reason we are involved in the process is because it does not work as it should.

We find that many cases are being remanded by the ALJs to the District Office of SSA and the DDSs for additional development and reconsideration of facts they have not previously considered. This points out two problems:

(1) The ALJ is agreeing with you that the case has not been

adequately developed at the lower level.

(2) The additional problem is the ALJ is then shirking responsibility by dismissing the hearing request and sending the case back for an additional period of delay while the SSA and DDS do another reconsideration of the issues.

We suggest to you that your bill should provide:

> "In the event a case is remanded because someone in the bureaucratic process fails or refuses to assume their responsibility by adequately developing the record and issues which are involved in the claimant's Social Security problem, then the claimant should immediately be placed in a 'pay status' until the reconsideration process has been completed."

Every level of the appeals process has its responsibility and if they are not doing their job, the claimants and their families should not suffer because of the failure on the part of bureaucracy to adequately develop the medical records and dispose of the issues in a case. Please remember that my remarks, while primarily addressed to the disability problems, do include the additional problems in the Social Security process including retirement, survivors and Medicaid questions.

Of course, I am not involved in the bureaucratic side of the process, but I do hear the complaints from the District Office that the DDSs will find anything in a file they can so as to send the case out of their office to the referring SSA District Office for "additional development." I have heard this ranged all the way from securing a medical report to getting the correct zip code on the application. The problem as it exists should be considered absurd. Each level, and they do consider themself professional in their jobs, should assume their responsibility and take the case as they find it, fully develop it and adjudicate it as soon as possible for the benefit of the claimant.

I request in all deliberations in connection with your reform act that you consider the number one item of concern in the whole process is the Social Security claimant. This is true whether the claimant is seeking disability, retirement, survivor, Medicare and/or Medicaid benefits. Please ask your staff and those in the policy-making divisions to always consider the number one object of this bill and that is the individual citizens who allege that they are entitled to the same. Whether they are right or whether they are wrong, they are entitled to courteous, expeditious and efficient consideration from the entire Social Security process whether it is a District Office, DDS, or ALJ office.

Taking your proposed amendments in order, I would like to comment on them as follows:

(1) Requirement for a face to face hearing: - We have been involved in several face to face hearings at the reconsideration level based on the experimental process which has taken place several times during the last 10 years. In almost all occasions, we have been impressed with the quality of the hearing and the hearing officer. The disagreeing part of the process has been the same thing as we experienced in all other initial and reconsideration reviews by the Social Security Administration. I have been handling Social Security cases of all kinds since 1965. During that period of time, I have seen this process grow into a very complicated system that gives one the feeling it is looking for a way to disallow claims rather pay claims. All of us know the history of the Social Security Act and what it was intended to be when it was first conceived. It has grown and promises have been made to the taxpayer each time Congress has decided to increase the

rate of contribution. There are those now who believe that we have billions of dollars in excess and would like to take those rights away. I suggest to you that in the last 10 to 15 years I have seen the Social Security Administration tighten its policies to the extent that one can almost feel the pressure being exerted to deny claims. When someone is confronted with this question, it is denied. However, if you look at the facts, it is obvious that something is wrong. Pursuant to its instructions from Congress, the Social Security Administration has adopted certain regulations interpreting the Social Security Act as it has been amended. We have been "blessed" with a Medical Listing of Impairments and also a Vocational Grid. These appear to be rather plain and straight forward. However, the problem comes at the initial and reconsideration level with the interpretation that is placed on these by the Social Security Administration.

We are constantly faced with the problem of the DDS issuing denial rationales which state that our claimants who have terminal illnesses can "be cured with proper treatment" within twelve months. We find that this is complicated by the fact that the DDS uses a continuing twelve months test rather than the alleged onset date. By this I mean if you allege you are disabled January 1, 1990 and your case is reviewed by DDS in February, 1990, they state you are not going to be disabled from your terminal cancer for twelve months, and you can be cured during that period of time, they will then upon reconsideration in approximately May or June state that you are going to well within another twelve months from the day of their decision (May, 1991). Your original onset date is January, 1990 and you should be entitled to your benefits twelve months later if you have an impairment which is disabling or reasonably expected to result in death. It is just a constant source of irritation to the citizens of the United States of America and their doctors to have non-examining (and in many instances) non-practicing physicians tell them that with "proper treatment" their cancer, their AIDS, their heart attacks, their strokes, their amputated limb, their comas, etc. all will get well within twelve months with "proper treatment."

The foregoing is even more embarrassing and disturbing when one considers the imposed "waiting period" that DDS applies to certain injuries and/or illnesses to see if the claimant is either going to get better, get worse, or die. This is done even before a decision is made whether the claimant is disabled under the Social Security Act. These are times that have been decided either by the Social Security Administration or the DDS within which they will wait before making a decision. This is true notwithstanding the normal five months waiting period that applies before an individual is entitled to any money, even if he is found disabled as of the first date of disability. Some examples of cases that are presently pending in the State of Georgia on which decisions have not been made are as follows:

(a) A 15 year old male with a brain stem injury due to an automobile accident was placed in the hospital on January 18, 1991. SSI was applied for on January 19th by the hospital personnel. The claimant has never left the hospital, and no decision has been made. The case has been "medically deferred by DDS to April 18, 1991." The patient has remained totally comatose for the entire hospitalization and of the date of dictation, no decision has been made as of yet.

(b) A 27 year old female has been hospitalized since December 16, 1990 due to an automobile accident. She sustained multiple head injuries, a diagnosis of hydrocephalus, she is not aware of time and place, has minimal speech and cannot move her extremities

intentionally. She cannot be fed externally except on a jejunostomy tube. Initially, she was fed by tube. Her case has been "medically deferred until May 15, 1991."

(c) A 62 year old male who sustained a cardiovascular accident (stroke) in March, 1991 is totally aphasiac, with a history of cardiac problems, blind in one eye, and transferred to a nursing home for care. His case has been "medically deferred by the DDS until June, 1990."

(d) A 51 year old male applied for disability benefits on October 15, 1990. He sustained a myocardial infarction on July 11, 1990, had bypass surgery in July, 1990, was readmitted to the hospital on an emergency basis in November, 1990. A cardiac catheterization showed repeated blocking of two main arteries, and a second bypass was performed. The claimant is on Nitroglycerin and suffers with angina daily. The case was "medically deferred initially for 90 days." The case has now been denied and is at the reconsideration level.

An additional problem that results from this which needs to be addressed by Congress is the fact that the Social Security Administration has avoided its responsibility of making "Medicaid only decisions" where the claimant has initially applied for SSI benefits and then dies before the Social Security Administration gets around to making a decision. This creates a problem because of the fact that since there are no "inheritance rights" with SSI, the claim for benefits normally dies with the claimant. However, the claim for Medicaid coverage is a continuing claim even after the death of the individual. Since the SSA and DDS are often very slow in making decisions, the claimant will die and the claimant's family is caught between the state welfare offices that administer Medicaid and the Social Security Administration which is supposed to make the determination as to disability. The Act should provide and make abundantly clear that in the event an SSI applicant dies prior to an adjudication the Social Security Administration will continue with the adjudication process and make a "Medicaid only decision" regarding the claimant's impairments and the disabling effects of the same.

An example of this would be a case recently where a 45 year old male had applied for benefits in June, 1990 due to severe Crohn's Disease. He had seven hospitalizations between July 25, 1990 and December 21, 1990.

His benefits were denied as of November, 1990 because they were nonsevere. The claimant died on December 21, 1990. Since there were no SSI cash benefits, Medicaid could only be allowed if there was a determination that the claimant was entitled to SSI by the Social Security Administration and this was not done. The family suffered immense financial problems because they had borrowed money to purchase medication and for medical treatment for the claimant pending the decision on his claim. Had his claim been approved while he was alive, he would have qualified for SSI and the Welfare Department would have issued Medicaid approval and would have been able to receive the medical treatment needed. Would he still be alive, I don't know.

Unfortunately, because of the delay that we are experiencing at the present time in the process, my office alone has experienced over 25 deaths of clients during the past twelve months while waiting on decisions. Under the current approach to the SSI and

Medicaid problem, this means that those claimants did not receive the kind of medical treatment they should have or could have received had they been allowed their SSI benefits and their Medicaid coverage.

Please include a provision requiring SSA to make a "medical only disability finding" if the claimant dies before decision.

We would also like to suggest that you have the Social Security Administration review its forms and delete repetitious forms. At the present time, the claimant is required to furnish the same information dealing with jobs, medical history, etc. at the initial and reconsideration level. If the reconsideration level is done away with, then the repetitious forms will be deleted also.

If Congress is going to provide for face to face hearings, we would like to recommend that the law require the Social Security Administration to hold a face to face hearing within 60 days of the application and that a decision be rendered no later than 30 days thereafter.

(2) Elimination of the process of reconsideration: I do not believe anyone in private practice who represents claimants can be found who will argue with you regarding this issue. We are all experiencing terrible delays. Most representatives I know work as hard as they can trying to get an adjudication made on behalf of their claimants. All of us are in daily contact (as your offices are) and have telephone calls from claimants who are losing their home, cannot afford medical treatment and losing custody of their children in many instances because they have no funds and are so disabled they cannot work to protect the same.

Therefore, anything which can be done by Congress to expedite this process will certainly be appreciated. I always have to express one caveat when I say this. We are not willing and not encouraging anyone to "short change" the rights of the claimants for the sake of expediency. The saying "Haste makes waste" can be applied if we try to move so fast we are willing to give up the claimant's right to a full and fair adjudication of the claims. To this end, some have mentioned the possibility of a "Social Security court." All of us have experienced the administrative court justice in the VA system and other administrative systems, and I know of no claimant's representatives who would be willing to tell you "It is a good idea." I think I can speak unanimously for almost every person I know involved in this process the right to go into the United States District Court guarantees the claimants a much fuller and fairer decision during the administrative process. The United States District Court judges I am familiar with are very capable of handling these cases and do an excellent job of recognizing the distinction "between bureaucratic law desires" and congressionally passed statutory laws.

(3) Medical Information to be -ted and Maintained in Making Disability Determinations. - This is a very grand idea but contains a problem. Many of our claimants are lucky if they can write their name. Even those who could write a narrative report would be lost totally under the process. I have represented everyone from total illiterates, who were severely mentally retarded, to scientists and presidents of large companies in their claims for benefits under the Social Security laws and regulations. Without exception, I find that almost all of them are intimidated by the process. I had a hearing last week involving an aeronautical scientist with a large national concern.

In each instance, the claimants were either intimidated or insulted by the process. In either event, they were unable to respond accurately to the questions submitted to them.

Many times we find that the initial application (especially under the current process of sending the same to the home of

applicant) is totally mystifying when you begin questioning the claimant regarding the same. The applications are often filled out by friends or relatives who believe they are completing a job application for the claimant. Therefore, they make glowing claims about the claimant's ability to mop, sweep, clean house, cook, grocery shop, fix automobiles, leap over a tall building, run faster than the speed of light and do any number of job-related activities. When the claimant reaches the hearing level and is asked about and denies the same, it appears that he is not credible. This is true many times when the claimant is totally illiterate, has never read or had read to him what was on the application and was only told "to sign on the line."

We are concerned about the amendment to 42 U.S.C. Sec. 421 (h)(1)(A) that requires a description of the individual's impairment offered for the record by such individual. There are offices that would deny a claim if this was the law because the claimant nor his family provided this detailed description. There should be a requirement the Social Security Administration should affirmatively seek the medical and other evidence needed to adjudicate the claim. It should provide without equivocation that as soon as sufficient evidence has been compiled which shows the claimant is in fact disabled as defined by the law and regulations, all further inquiries should stop and an immediate favorable decision should be issued at that time without any further delay.

42 U.S.C. Sec. 421(h)(1)(C) should be amended to read as follows:

> "Medical records and residual functional capacity, residual mental capacity, assessment of pain and other assessments relating to such individual from physicians, psychologists, and other therapists treating the individual since the alleged onset of disability;"

The Courts and Congress have continually recognized there is none better to assess the physical and mental capacity of the claimant than those who are continuously treating and are responsible for the treatment of the claimants' condition.

We would recommend that 42 U.S.C. Sec. 421(b)(1)(D) be amended to read as follows:

> "Reports of any consultative examinations, assessments of residual functional capacity, assessments of pain, and other assessments relating to the individual's case which have been performed by or under the Secretary (which reports, etc. shall not be conclusive or exclusive of other reports and assessments that are submitted by the claimant's treating sources)."

The way the current proposed amendment to the Social Security Act reads it would interpreted by SSA to mean that only the Secretary or designated persons by the Secretary could perform or direct what type and what would be contained in reports of consultative examinations, assessments of residual functional capacity, assessments of pain and other assessments relating to the individual's case. We have seen this happen time and time again. It is absolutely absurd what is happening throughout the United States. There are countless numbers of dollars, time and humiliation inflicted because of the Secretary's attempt to circumvent the conclusions of very competent treating sources. The Secretary, through its doctors who work at the DDS, are continuously contradicting the specialists the Secretary has selected to do consultative examinations.

We are continuously confronted in Georgia with one of the

State Agency physicians contradicting a specialist who is Board Certified in performing pulmonary function study tests. The consulting examiner will examine a patient, report the results of his pulmonary function studies and state that he received full and good cooperation from the claimant. The State Agency physician will then deny the results of the consulting examination because upon examination of the doctor's report the State Agency physician decides there was not "good patient effort" and the test results are invalid. We have had this occur where EEGs, EKGs, MRIs, blood tests, urine tests and all types of other tests were done. The doctor who actually performed the test would submit one report and the rationale from the DDS physician would totally contradict those findings notwithstanding the fact that the DDS physician did not examine the patient or perform any tests whatsoever.

Consequently, we submit to you that it is a very dangerous precedent to state that assessments of any kind can only be considered if they were "performed by or under the Secretary."

I would also like to suggest to you that the same arguments as just given apply to the proposed amendment to Sec. 421(h)(1)(E)(2). I will assure you this will immediately be interpreted by the Social Security Administration and the DDS to mean that only the doctors who work for DDS or who are specifically employed by the Social Security Administration will be allowed to give any mental assessment or mental residual functional capacity assessment. We would suggest to you that nothing would make SSA and those who would seek to deny benefits to the claimant any happier. Some of the problems we are faced with concerning the government's assessment of an individual's mental capacity are unbelievable. I have had cases where the government would refer to the fact that a claimant who had tried to kill himself, his spouse or others only suffered a minimal ability to socially adjust to circumstances and had no severe impairment which would interfere with his ability to get along with co-workers, supervisors and others. We experience the same problem here that we do with the physical examinations. The psychologists or psychiatrists hired by the DDS will exert a contradiction to the claimant's treating psychologist or psychiatrist or even their own employed consultative examiner who did psychiatric or psychological testing. The doctors can state that the claimant has given full cooperation and done their best on the various mental tests, and the DDS "qualified psychiatrist or psychologist" will contradict the Board Certified psychologist or psychiatrist and state that the patient (claimant) did not fully cooperate. We urge you to disregard this so that the paragraph will read as follows:

> "In any case in which there is evidence which indicates the existence of a mental impairment, the Social Security Administration shall secure the treating psychiatrist's or psychologist's records and seek to secure a residual functional capacity assessment from the treating psychiatrist or psychologist."

By adopting this amendment, there is nothing that prohibits the Social Security Administration from continuing to employ independent consulting examiners and to review the evidence. However, any review should be done only upon setting forth specific factual rationale for disagreeing with previous assessments submitted. Any assessment based on the DDS psychiatrist's or psychologist's "personal feeling" about the case should be discouraged and disallowed.

I believe a lot of the problems we experience with DDS could be eliminated if the following were done:

> (a) Any and all rules submitted by the SSA to DDS as to the method and means by which they interpret physical and mental evidence should

be made public and available upon request by claimant and claimant's representatives.

(b) All internal directives at the DDS regarding "how we will look at certain impairments and when we will evaluate those claimants' impairments" should be made public and implemented only after public disclosure and notice of the same has been given.

(c) There should be an advisory panel made up of DDS personnel, SSA personnel, practitioners who represent claimants and lay persons who should be required to approve any and all internal policies regarding deviation by DDS from the rules, regulations and laws as promulgated by Congress and by the Social Security Administration.

This Committee should also be considered as a general "overview committee" as to the methodology and practices of the DDSs and should also be informed of any and all complaints against the DDS and/or any of its personnel (full-time, part-time or by contract such as consulting examiners). This panel should have a full cross-section of Social Security, DDS and private practitioner representation.

Finally, I would like to request that this Committee consider some additional areas as to amendment:

(a) Please consider providing that no case shall be dismissed for "late" filing of an application or an appeal until the claimant has been given an opportunity to present evidence justifying "good cause" for the late filing.

(b) Please pass a law that states DDSs are not authorized to decide cases under internal regulation promulgated by them or SSA if the same conflict with the laws of the United States or the regulations dealing with Social Security matters.

(c) Please provide that if a claim is pending at any level of the adjudicatory process for more than four months without a decision that claimant be put in a "pay status" from that point until a final adjudication is made in connection with the claim.

(d) Please consider an amendment that would require the Social Security Administration to consider hiring practices of employers throughout the United States in making a determination as to disability. At the present time, we only consider age, education, past relevant work experience, the severity and effect of the claimant's impairments. All of us in the "real world" know a claimant who has occasional seizures, a bad heart, has had two or more back surgeries, has HIV positive findings, has been convicted of a crime because of severe mental and emotional imbalance and still suffer from the condition, et al. are all not going to be employed because of hiring practices. We are all familiar with the disability hiring protection laws that have been passed. This is a step in the right direction but it does not address

the problem facing the SSI and Social Security applicant for disability benefits. The hiring practices, if they are in fact real and exist in the work place, should be considered as one of the elements in making the disability determination.

(e) Please consider some type of amendment to the Social Security Act so as to encourage individuals to return to work. Many times claimants are afraid to try and return to work because of the repercussions that occur from the attempt. If the individual tries to work, he will generally lose his Social Security benefits, Medicare coverage, long-term disability coverage, group insurance, etc. Therefore, the safest way is, once you are on disability, stay on disability.

We would also like for you to consider some type of a grievance procedure mandated by Congress. In the event a claimant or applicant for Social Security and/or SSI benefits (including Medicare and Medicaid) is harassed or subjected to humiliating belligerent treatment by SSA or DDS personnel, the claimant should have some type of a published grievance procedure available to them.

We do thank you and your Committee for allowing us the opportunity to testify here today. Thank you for recognizing there is a significant problem with delays and quality of development in these cases.

We believe your proposed changes in the law are good but they do need the safeguards for the claimant we have suggested.

Thank you for your consideration.

Professor Robert E. Rains
The Dickinson School of Law
150 S. College St.
Carlisle, PA 17013
717-243-4611

May 13, 1991

Robert J. Leonard, Esquire
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Bldg.
Washington, DC 20515

re: The "Social Security Appeals Process Reform Act of 1991," H.R. 1799

Dear Mr. Leonard:

I am writing in support of H.R. 1799, "The Social Security Appeals Process Reform Act of 1991". This statement is made in my capacity as a law professor and supervisor of the Disability Law Clinic of the Dickinson School of Law. I am not writing on behalf of any individual claimant or any organization, although I have represented hundreds of claimants for Social Security Disability Insurance Benefits and Supplemental Security Income, first in private practice and then as supervisor of the Disability Law Clinic. Although I am a member of the National Organization of Social Security Claimants' Representatives (NOSSCR), I am not making this statement as a representative or spokesman for that organization.

Any attorney who has had any significant involvement with the Social Security appeals process is well familiar with the many frustrations involved in that process. Deserving claimants wait for months, and often for years, to obtain benefits which they desperately need and for which it is obvious to the attorney at the initial interview they are eligible. Delays in the system are notorious. I have personally handled cases that stretched over the course of many years. One of my cases took eight years from application until the disabled claimant received his first payment. I am familiar with cases handled by other attorneys which have taken longer. My former law partner recently concluded a case in which the claimant's widow has just received benefits based on her deceased husband's disability some seven years after his death. Some cases stretch more than a decade. While cases stretching over many years are undoubtedly atypical, cases stretching one to three years are quite commonplace.

Indeed, the problem of delays within the Social Security system has been addressed by the Supreme Court of the United States. In Heckler v. Day, 467 U.S. 104 (1984), the Court refused to uphold an order directing the timely adjudication of claims, in large part because Congress was well aware of the problem and had failed to enact corrective legislation.

H.R. 1799 is a vehicle by which the Congress could enact a significant improvement in the system. The relatively small percentage of claimants who receive their benefits upon reconsideration in no way justifies the delay to which all other claimants are subjected, nor the cost to the system as a whole. The costs of funding reconsideration

could be much better applied to upgrading the initial application stage.

There are two large groups of claimants who, in my view, would be particularly benefitted from some sort of face-to-face meeting with the state agency adjudicator at the initial application stage. These are claimants with mental illness or mental retardation, or both. All too frequently we see such claimants at the Disability Law Clinic who are ruled by the state agency to be capable of substantial gainful activity. No reasonable person observing these claimants directly would likely draw such a conclusion. I refer to those claimants who cannot answer a direct question, ramble interminably, become extremely agitated or stare into space, are overly concerned about people or aliens or things that are out to get them, and in many cases, frankly smell so bad that one's office has to be aired out for hours afterwards. Repeatedly we find that the reviewing doctors and psychologists in the state agency, who never see these claimants, check off the little boxes on their little forms that they are capable of basic unskilled work and meeting the demands of the workplace. Not only could these claimants not meet the demands of any workplace, but they often cannot meet the most basic demands of living in our society in any consistently meaningful fashion.

While H.R. 1799 would be a great advance, even something less formal than an evidentiary hearing would be extremely useful. At the very least, requiring the state agency adjudicator to have an unrecorded face-to-face interview with the claimant, unless he or she has already found that the claimant meets a Listing, would go a long way to avoid the obviously wrongful denials.

I have previously written about problems within the Social Security system, including the delays to which it is chronically subject. I am enclosing six copies of my article "A Specialized Court for Social Security? A Critique of Recent Proposals," Florida State University Law Review, Volume 15, No. 1 (Spring 1987). I understand that this will not be accepted for printing but will be maintained in the Committee files for review and use by the Committee.

I understand that the Social Security Administration has testified in opposition to H.R. 1799. It is ironic that the Administration continuously accuses private attorneys of delaying the resolution of their clients' cases in order to increase their back awards and hence the potential attorneys fees. Now when the bar is once again testifying in favor of a modest proposal that would eliminate one largely useless step in the process, the Social Security Administration is opposed to it. The Social Security system knows full well that a substantial proportion of claimants drop off at each stage of the process by failing to appeal to the next step. Unfortunately, it is precisely the mental ill and mentally retarded claimants who are most likely not to follow through, as any advocate is well aware. By improving the initial determination stage and eliminating the reconsideration stage, Congress would take a big step toward ameliorating this problem.

Sincerely,

Robert E. Rains

Robert E. Rains
Professor of Law

Enclosures

[THE ENCLOSURE TO THIS LETTER IS BEING RETAINED IN THE COMMITTEE FILES.]

County of Santa Clara
Social Services Agency

1725 Technology Drive
San Jose, California 95110-1360

MAY 21 RECD

May 13, 1991

Congressman Andrew Jacobs, Jr., Chairman
Subcommittee on Social Security
Committee on Ways and Means
United States House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

RE: H.R. 1799 - DISABILITY APPEALS
PROCESS REFORM ACT OF 1991

Dear Congressman Jacobs:

The Social Services Agency of Santa Clara County, California, has long been concerned about the lengthy and difficult process with which disabled applicants struggle in order to prove eligibility for SSI. We are gratified to learn that you are introducing legislation which will address some of the problems involving the SSI decision-making process. We welcome the opportunity to respond to your invitation to add our suggestions for improving the accuracy of Social Services Administration (SSA) decisions on disability and streamlining agency appeal procedures.

H.R. 1799, the Disability Appeals Process Reform Act of 1991, proposes three major changes in the way applications for disability are processed. Our comments, which are based on our agency's experience in advising, representing, and advocating for SSI applicants, will address these three issues.

I. The first provision of H.R. 1799 would "require SSA (Social Security Administration) to provide initial face-to-face interviews for all applicants for disability benefits."

Instead of requiring a face-to-face interview at the initial application level, we support a mandatory face-to-face interview when an SSI application is about to be denied. Further, we suggest that the interview be conducted by a person who has been given the authority to approve the SSI application when applicants have met the disability requirements. We further suggest:

A. In those cases where the claimant is bedbound or otherwise unavailable, the face-to-face interview provision should not be mandatory since this process might create a delay.

B. At the time of initial SSI application, applicants be provided with instructions that clearly describe the type of information needed in order for a determination of SSI eligibility to be made.

Board of Supervisors: Michael M. Honda, Zoe Lofgren, Rod Gonzales, Ted Dreyfus, Dianne McKenna
County Executive: Sally R. Reed

RE: H.R. 1799

C. Applicants be given an explanation about how this information will be used, and why it is necessary.

D. Claims Representatives be required to observe and always document conditions or behaviors of applicants that would assist the Disability Evaluator to have a clearer understanding of the applicant's functioning. (One of our clients actually had a seizure in the Social Security Office, but it was not noted in the SSI case record.)

E. Claims Representatives be required to refer for advocacy services those applicants who appear to be having difficulty understanding the requirements of eligibility process or who appear unlikely to be able to follow through without assistance. Such a referral would be mandatory in all cases where a mental or neurological impairment exists or is reasonably inferred.

F. Presumptive Approval be given to applicants who can show that they have provided medical evidence of disability and have been exempted from the work requirements of General Assistance/Relief programs for 12 or more months. Santa Clara County's General Assistance medical form (attached) specifically spells out guidelines for physicians that are identical or are very close to Social Security's own guidelines. An appropriately completed medical declaration could be used as sufficient evidence for approving SSI presumptively.

II. H.R. 1799 would "eliminate Reconsideration".

This proposal is presumably made to speed up the decision-making process. Eliminating the Reconsideration step may appear to speed up the process, however, we believe that this step is necessary and should remain.

A. Reconsideration gives the applicant time to supply further medical evidence after learning why an initial denial was made.

B. With Reconsideration eliminated, the case will proceed to Hearing, and the applicant will have to bear the costs of legal representation without having had the opportunity of providing further convincing medical evidence on his/her own.

III. H.R. 1799 directs the Social Security Administration "to develop more comprehensive initial evidence of the claimant's condition".

The Social Security Administration is presently unable to document and develop evidence of qualifying disability, and it is doubtful that this mandate could be accomplished within the current Social Security system, given the staffing and funding levels. The present classification of Social Security employees (Claims Representatives and Analysts) are not well-suited to also be claimant advocates. A claimant advocate or social worker is needed to interact with and gain the confidence and trust of many claimants as a prerequisite to developing evidence of disability. To add the responsibility to existing SSA staff might contribute to a delay in the decision-making process.

RE: H.R. 1799

As an alternative, Social Security should be required to make referrals for advocacy services at the point of denial of initial application. Many claimants are incapable of documenting their own disabilities. When these claimants receive advocacy assistance in the documentation process, the effort is usually successful.

Therefore, we believe that federal funding should be provided to local (private, state or county) social services agencies to provide advocates to develop and provide documentation of claimant's disability. We further suggest:

A. Requests made by Social Security for medical evidence should be all inclusive and show past medical history as well as current medical conditions. Currently, Social Security Administration only requests the most recent medical information which does not depict the disability as it has developed over time.

B. Referrals for advocacy services should always be made when claimants are mentally ill or neurologically impaired, and do not have a guardian or representative.

C. Forms that are provided to applicants and/or persons who have knowledge of their conditions, should be designed to more clearly demonstrate the applicant's functioning on a daily basis. The present structuring of the forms asks very general questions that actually require very specific responses in order to show disability. A form asking specific questions about functioning with the possibility of "multiple choice" answers might be more appropriate and relevant. We also recommend that forms be available in the predominant languages of the area (e.g., Spanish, Vietnamese or Chinese in the San Francisco Bay Area).

D. Family doctors or treating physicians should be paid an appropriate fee for writing reports. Many doctors are unwilling to write reports for patients who are unable to pay for their time, and analysts are often unable to read lengthy, handwritten case notes. A typewritten report or statement by the treating physician or facility would provide more reliable information about the applicant's condition, and eliminate the need for many consultative examinations. Payments could be based on surveys of the local market, or physicians could be allowed to bill Medicaid (Medi-Cal in California) for these evaluations whether or not the claim is ultimately approved.

E. Hearings before an Administrative Law Judge should not go forward unless the applicant is adequately represented. Where a mental or neurological impairment exists, the appointment of an attorney or advocate should be mandated by the Social Security Administration.

F. Attorney fees for representing SSI claimants, upon approval, should be paid directly to the attorneys by the Social Security Administration, as is the current practice under Title II. Many attorneys will not accept SSI cases due to the difficulty of securing payment from a disabled and/or indigent SSI claimant.

RE: H.R. 1799

G. Advisory Groups, which tend to be cumbersome and political, do not appear to be a viable option, at least at the local level. We believe that advocacy programs, which offer direct assistance to the applicant, are more appropriate to specifically address the variety of problems which exist.

In Santa Clara County, we find that an initial application takes at least six months for a decision, Reconsiderations take another six months, and Hearing decisions take six to 12 months. Clients who do not have advocates to assist them, unfortunately, have an even longer wait for their SSI decisions.

Sincerely,

RICHARD R. O'NEIL
DIRECTOR

RRO:bh

Attachment

cc: Congressman Norman Y. Mineta
Congressman Don Edwards

SANTA CLARA COUNTY SOCIAL SERVICES AGENCY

GENERAL ASSISTANCE PROGRAM
REQUEST FOR MEDICAL INFORMATION

INSTRUCTIONS TO PHYSICIAN: The individual named below claims to be physically or mentally incapacitated and unable to engage in basic activities. This report should provide an assessment of any medically verifiable condition(s) which would prevent or limit the patient from accepting and/or keeping employment. GUIDELINES MAY BE FOUND ON THE REVERSE SIDE OF THIS FORM.

Patient's Name _____ Case # _____ Birthdate _____ Social Security # _____ Chart # _____

Worker's Signature and District _____ Telephone Number _____ Date _____

PATIENT AUTHORIZATION: I authorize the release to the Social Services Agency any medical information necessary to assess my eligibility and status for programs of this department including information related to drug, alcohol or psychiatric conditions. I feel my employability is limited because _____

This authorization is valid until _____ or one year from the signing.

Patient's Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN

I. Present Diagnosis _____

II. Prognosis _____

III. Does this impairment constitute a disability? Yes ☐ No ☐ If yes, to what degree?

IV. Extent and duration of this impairment. Please be specific in describing the limitation on physical/mental activities, work activities to avoid, and the duration of this disability if any.

V. Does this patient require care and/or supervision in a Board and Care Facility? Yes ☐ No ☐ If yes, how long?

VI. Date of last examination _____ Next appointment _____

Physician's Signature _____ Phone ( ) _____

Address _____ City _____ Zip _____

Date _____

Please return this form to: SANTA CLARA COUNTY SOCIAL SERVICES AGENCY

Address _____ City _____ Zip _____

EMPLOYABILITY GUIDELINES FOR GENERAL ASSISTANCE

UNEMPLOYABLE DEFINED

To be classified as "unemployable", an applicant/patient must have an impairment, either temporary or permanent, which will significantly limit his/her physical or mental ability to do basic work activities, without regard to age, education or work experience.

If the impairment will prevent the individual from engaging in the work activities that she/he has performed in the past, the applicant/patient's age, education and work experience will be considered in determining employability.

"Basic work activities" are the abilities and aptitudes necessary to do most jobs.

(a) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying or handling.

(b) Capacities for seeing, hearing, and speaking.

(c) Understanding, carrying out, and remembering simple instructions.

(d) Use of judgment.

(e) Responding appropriately to supervision, co-workers and usual work situation; and

(f) Dealing with changes in a routine work setting.

EMPLOYABLE WITH LIMITATIONS

When the applicant/patient possesses one or more of the above abilities and in your opinion could function in an employment setting with certain restrictions.

EMPLOYABLE

An individual who does not possess any physical or mental barrier to the performance of "basic work activities" as defined above.

STATEMENT BY GEORGE H. THOMASON, ATTORNEY
P. O. BOX 772
SPARTANBURG, SOUTH CAROLINA 29304
SUBJECT: H.R. 1799

An initial Social Security disability determination should not be made by Social Security until the Secretary has made every reasonable effort to obtain medical records, consultative examinations, assessments of residual functional capacity, and reports by social workers, therapists, mental health workers, etc. Clarification should occur with regard to lines 3 and 4 on page 4 of the Bill; line 7 on page 4 of the Bill; lines 11 and 12; and lines 16 and 17 on page 4 of H.R. 1799. The proposed legislation requires the Secretary to obtain medical records "since the alleged onset of the disability." This is the language that I find objectionable on this page of the Bill. The Secretary of Health and Human Services should be obligated to obtain "all pertinent medical records" relating to the period of disability. This is especially important in mental cases where repeated periods of hospitalization and long term mental health care records may be in existence for several years prior to the date that disability finally commenced. It is also important for individuals who have had repeated periods of hospitalization for treatment of pain, seizures, back surgeries, cancer surgeries, chemotherapy, etc. Pertinent medical information concerning these types of medical histories should be developed by the state agency. Certainly the Secretary should not be required to develop medical records of no consequence. However, a lot of important medical records exist for many Social Security disability claimants before the date that disability finally forced the wage earner to stop working.

I am particularly worried about language contained in lines 11 and 12 on page 4 of the proposed legislation. This appears to restrict claimants from arranging for consultative examinations. It appears to give greater weight to medical information that the Secretary can develop through consultative exams and assessments of residual functional capacity. This would have a horrendous impact on proper development and consideration of disability applications. I am confident this will be used negatively in thousands of disability claims. Please delete this language from the proposed legislation or make it clear that consultative examinations and assessments of residual functional capacity can also be submitted from treating sources or consulting sources by the claimant.

Face-to-face interviews with disability examiners working for state agencies will be meaningless. They don't give any consideration to detailed interview material that is already submitted to them in disability reports completed by district office personnel. Subjective complaints regarding pain and functional limitations are given no consideration at this point in time. Why should we believe that state agency officials are going to perform a better job if they are afforded face-to-face interview opportunities? The standard that is used must be addressed and rectified.

Respectfully Submitted,

THOMASON & FRENCH

George H. Thomason
Attorney at Law

May 13, 1991